DBHDS Jump-Start Acknowledgement & Assignment of Award

Service providers applying for a Jump-Start funding on an individual's behalf to support his/her access to community-based services. Providers will offer supports in an area where there is limited availability of a specific service and must review and complete this form with the individual, and then submit this form with the application or before funds are distributed.

Individual

First Name ______________________________ Last Name______________________________________

Street Address ____

City ____________________________________ State ______________ Zip Code __________________

Individual's Authorized Representative (if needed)

First Name ______________________________ Last Name______________________________________

Street Address ____

City ____________________________________ State ______________ Zip Code __________________

Service Provider Representative

Agency Name ____(hereinafter, "Provider Agency")

First Name______________________________ Last Name _____________________________________

Title ___________________________________

Street Address ____

City ____________________________________ State ______________ Zip Code __________________

Acknowledgements

I, ____ (individual's name), have selected the above referenced Provider Agency to be my Medicaid Developmental Disabilities Waiver provider of _________________________ (Medicaid Waiver service) after considering all alternative providers and options.

I understand that the Provider Agency is applying for a DBHDS JumpStart funding on my behalf to cover certain one-time costs that will help build its capacity to provide _________________________ (Medicaid Waiver service).

If DBHDS awards this Jump-Start funding to me, I agree to assign the grant award directly to the Provider Agency for use on my behalf. I understand that, if I choose to terminate the services of Provider Agency, I cannot cash out this grant award or reassign it to another service provider.

____ ____________________________________

Signature of Individual | Date

____ ____________________________________

Signature of Authorized Representative | Date

____ ____________________________________

Signature of Service Provider Representative | Date

____ __________________________________

Signature of Support Coordinator (optional) | Date