



**OKLAHOMA DEPARTMENT OF HUMAN SERVICES**

**Family Support Assistance Payment  
Services Application**



**Section 1. Child information.** Complete for the child with developmental disabilities for whom you are making application.

**Child 1**

Last name		First		Middle	Date of birth
Age	Race		Gender		Social Security number
Child adopted Yes <input type="checkbox"/> No <input type="checkbox"/>	Adoption subsidy Yes <input type="checkbox"/> No <input type="checkbox"/>		Medical subsidy Yes <input type="checkbox"/> No <input type="checkbox"/>		Live in your home Yes <input type="checkbox"/> No <input type="checkbox"/>

**Section 2. Parent or legal guardian to be assigned payee.**

Last name		First		Middle	Date of birth
Relationship		Social Security number		Area code	Phone
Street address					
City			State	Zip	County
Spouse last name		First		Middle	Date of birth
Relationship		Social Security number		Area code	Phone

**Section 3. Additional children.** Complete if applying for more than one child with developmental disabilities.

**Child 2**

Last name		First		Middle	Date of birth
Age	Race		Gender		Social Security number
Child adopted Yes <input type="checkbox"/> No <input type="checkbox"/>	Adoption subsidy Yes <input type="checkbox"/> No <input type="checkbox"/>		Medical subsidy Yes <input type="checkbox"/> No <input type="checkbox"/>		Live in your home Yes <input type="checkbox"/> No <input type="checkbox"/>

**Complete and sign page 2**

**Child 3**

Last name		First	Middle	Date of birth
Age	Race		Gender	Social Security number
Child adopted Yes <input type="checkbox"/> No <input type="checkbox"/>	Adoption subsidy Yes <input type="checkbox"/> No <input type="checkbox"/>	Medical subsidy Yes <input type="checkbox"/> No <input type="checkbox"/>		Live in your home Yes <input type="checkbox"/> No <input type="checkbox"/>

**Child 4**

Last name		First	Middle	Date of birth
Age	Race		Gender	Social Security number
Child adopted Yes <input type="checkbox"/> No <input type="checkbox"/>	Adoption subsidy Yes <input type="checkbox"/> No <input type="checkbox"/>	Medical subsidy Yes <input type="checkbox"/> No <input type="checkbox"/>		Live in your home Yes <input type="checkbox"/> No <input type="checkbox"/>

I declare this information is true. If there is a change in information provided, I will notify OKDHS at the address listed on this application within ten days of the change. I understand providing false information or failing to provide notice of changes in information may result in denial of eligibility, termination of payment, repayment of any amount not appropriately received, and perjury penalties as provided by law.

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 Parent/guardian signature

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 Date
**Section 4. Attachments.**

For each child with developmental disabilities for whom you are making application, submit:

- copy of child's birth certificate. If child receives OKDHS services, copy of child's birth certificate is not necessary, unless requested;
- signed copy of your most recent federal income tax return and verification, such as Supplemental Security Income (SSI), child support, alimony, or other subsidy;
- **Section 5, Developmental disabilities verification, page 3** of this application, which requires signature by the child's doctor or school or SoonerStart designee;
- copy of your child's Social Security card; and
- copy of legal guardianship established by the court, if applicable.

**Copies of attachments are not returned.** You must provide this information at time of application. If not, your application is considered incomplete and returned to you.

Return completed application, including all required information and signed Section 5 to:

Oklahoma Department of Human Services  
 Developmental Disabilities Services Division - FSAP  
 P.O. Box 25352  
 Oklahoma City, OK 73125-0352

State Office use: Application  Review

**Section 5. Developmental disabilities verification.**

Doctor or school designee: \_\_\_\_\_

I, as parent/guardian, request the information below be released to verify child's developmental disability for the Family Support Assistance Program (FSAP).

Child last name	First	Middle	Date of birth
Print parent/guardian name			

\_\_\_\_\_  
Parent/guardian signature Date

**This information is completed by doctor or school designee only. Initial all responses.**

1. List child's primary and other diagnoses. \_\_\_\_\_
2. Does child have mental retardation? Yes \_\_\_\_\_ No \_\_\_\_\_
3. Does child have cerebral palsy? Yes \_\_\_\_\_ No \_\_\_\_\_
4. Does child have autism? Yes \_\_\_\_\_ No \_\_\_\_\_
5. Is this condition likely to continue indefinitely? Yes \_\_\_\_\_ No \_\_\_\_\_
6. Because of this condition, not age, which areas result in substantial functional limitations:
  - self-care Yes \_\_\_\_\_ No \_\_\_\_\_
  - receptive and expressive language Yes \_\_\_\_\_ No \_\_\_\_\_
  - learning Yes \_\_\_\_\_ No \_\_\_\_\_
  - mobility Yes \_\_\_\_\_ No \_\_\_\_\_
  - self-direction Yes \_\_\_\_\_ No \_\_\_\_\_
  - capacity for independent living Yes \_\_\_\_\_ No \_\_\_\_\_
  - economic self-sufficiency Yes \_\_\_\_\_ No \_\_\_\_\_
7. Does the need exist for a combination of interdisciplinary or generic care or treatment, individually planned and coordinated for life or extended duration? Yes \_\_\_\_\_ No \_\_\_\_\_

Per Section 1408 of Title 10 of the Oklahoma Statutes, the term developmental disability does not include persons who are solely mentally ill.

**I verify the information regarding the child is correct.**

\_\_\_\_\_  
Signature of professional Date

Print name and title	Area code	Phone
Street address	City	State Zip

Return to: Oklahoma Department of Human Services  
 Developmental Disabilities Services Division - FSAP  
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 Oklahoma City, OK 73125-0352