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 and supports in an area where there is limited availability of a specific service must review and complete this form with the individual, and submit this form with the application.

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).

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