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

Reset Form

Rev 07.19.2022