

## LifePath Systems County Support Grant

### Assurances and Signature Page

- My signature below verifies that I have submitted accurate information and am in agreement with the provisions of the County Support Program requirements.
- **I understand that I am responsible to report changes in residency, telephone number, diagnosis and/or income within 10 days** for re-evaluation to determine eligibility to continue in the program. Termination of support occurs when eligibility requirements can no longer be met or the consumer/family chooses to exit the program. A consumer or family will be exited from the program and be liable for restitution for:
  - 1) purchasing items or services that have not been approved in the Written Plan
  - 2) use of funds in a method not approved in the written plan. Your plan must be followed as written; funds not utilized in the time period specified in the plan will be recouped. Changes to the plan must be made in advance.
  - 3) Failure to notify of enrollment in a comprehensive waiver program.
  - 4) Failure to notify of change in income or Medicaid/private insurance eligibility.
- **Receipts must be received by the 30<sup>th</sup> day after the delivery of the service or support. Receipts received after the 30<sup>th</sup> day will not be reimbursed.**
- **I understand that the purchases/services must be approved in the Written Service Plan prior to the purchase/service or they will not be reimbursed.**
- I understand that the vendor for adaptive equipment or minor home modifications (any item purchased with bids) selected to render the services in the plan is the vendor that must be used and any change must be agreed to by LifePath Systems County Support Grant staff prior to the change.
- I understand that funds must be used according to the Written Plan and that any change in the use of funding without prior approval will not be reimbursed.
- I am not participating in any other In-Home & Family Support Program. I also am not receiving services through HCS, ICF-MR, CBA, CLASS, MDCP, TxHmL or other comprehensive waiver program. I must notify the program coordinator within 10 days if I enroll in HCS, ICF-MR, CBA, CLASS, MDCP, TxHmL or other comprehensive waiver program during the fiscal year. Termination of support occurs upon enrollment in a waiver program.
- When a family/consumer exits the program voluntarily, new requests for County Support Grant funds will be processed in chronological order and may necessitate the consumer/family to be placed on a waiting list.
- I agree that I am responsible for providing all required documentation and receipts.
- All approved services must be paid for by the family and will be reimbursed by The County Support Grant.
- I understand that receipts must:
  - 1) state the total amount of cost; including copayment,
  - 2) state the date the services were provided, purchased, or delivered,
  - 3) include the name of the vendor and identifying information,
  - 4) be marked PAID
  - 5) must include the name of the person served
  - 6) service logs must be signed by the provider of services.
- I understand it is a felony of the third degree to knowingly make or cause to be made a false statement or representation or to solicit or accept support for which I know I am ineligible.
- I attest that if I am a child support obligor, I am not more than 30 days delinquent in paying child support or are in compliance with a written repayment agreement or court order regarding any existing delinquency.
- I understand that I am responsible for resolving any disputes with a vendor, contractor, or individual paid with County Support Grant assistance.
- I understand that a Written Plan is not a guarantee of twelve months of payment. The agency will perform a budget analysis every month during the fiscal year to determine available dollars and allowable expenses for the following month. I understand that if it appears that my funds will not be utilized by the end of the fiscal year, or if they are not used as outlined in the plan, funds will be re-appropriated to other applicants.
- I understand that I am responsible for the selection and/or supervision of any provider, and agree to hold LifePath Systems harmless from any accident/injury which may occur.

\_\_\_\_\_  
Signature of Applicant or Parent/Guardian of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of County Support Grant Coordinator

\_\_\_\_\_  
Date