



Dear Family:

With each new fiscal year comes the time to renew your Family Support paperwork. This paperwork helps us to keep your family member's information current so that we may best meet their needs and the needs of your family.

Recent state budget cuts have created the need to change how Family Support delivers services to your family. Your Family Support Service Coordinators (FSSC) will continue to be available as a resource for information and referrals only. High School Transition Case Management and Services will be limited to individuals with Medicaid. Please contact the Department of Health & Human Services (DHHS) District office at 1-800-852-0632 or 603-883-7726 to apply.

As of April 2003, the Health Insurance Portability and Accountability Act (HIPAA) require that Gateways Community Services obtain signed Consent to Bill for services funded by NH Medicaid. **Please note that billing Medicaid for these services will not impact the caps or limits for other Medicaid covered services such as therapy. Your prompt response in signing and returning the enclosed paperwork is needed in order for us to be able to continue to provide services with NH Medicaid funding.**

Enclosed you will find the Family Support Information Sheet, the Family Support Service Agreement and Consent to Bill form (Medicaid recipients only). We ask that you fill out each form in its entirety and return them to Gateways Community Services by September 30, 2011.

Families can use Gateways Community Services respite providers or respite providers hired by the family. Enclosed is a copy of the Respite Reimbursement Voucher for families hiring their own Providers, restrictions may apply. Respite vouchers are due by the 10<sup>th</sup> of the following month. This form may be downloaded from <http://www.gatewayscs.org>. **Note: Gateways has a Respite Reimbursement policy limiting annual respite reimbursement to \$1,699.** Gateways can assist you in hiring your Respite Provider as a Gateways employee. Families who choose to use Gateways Community Services respite providers must complete the enclosed Respite Care Profile. The profile may be downloaded from <http://www.gatewayscs.org> or sent to you at your request. Gateways Community Services cannot provide you with a respite provider unless there is a Respite Profile on file.

Discretionary Funds will continue to be available to families who require assistance for other expenses directly related to your developmentally disabled family member. If you require assistance, please contact Family Support to obtain a Council Discretionary Funds Request Form, or you may download this form from [http://www.gatewayscs.org/fs\\_funds.htm](http://www.gatewayscs.org/fs_funds.htm). These applications are reviewed anonymously for approval by the FS Council Discretionary Fund Committee.

Please contact Carole Poulin at (603)459-2705 if you have any questions.

Sincerely,

***Family Support Staff & Family Support Advisory Council***

144 Canal Street, Nashua, NH 03064 • (603) 882-6333 • Fax (603) 889-5460 • [www.gatewayscs.org](http://www.gatewayscs.org)

Service Agreement Cover Letter  
Revision: 8/18/2011



**Family Support Council  
Service Agreement**

Name: \_\_\_\_\_  
(Eligible Participant)

The following allocations are for fiscal year 2012 (7/1/11-6/30/12). If the funds are not utilized in the first half (July 1 to December 31) of the year, they cannot be utilized in the second half (January 1 to June 30) without prior approval.

Gateways Community Services reserves the right to change this allocation during the year depending on funding, or family circumstances.

Your family is allocated: \$330 to be used from July 1 to December 31, 2011  
\$330 to be used from January 1 to June 30, 2012

The Respite Allocation will be used by the family in the following manner (please check):

- Respite provided by Gateways Community Services
- Family will hire respite provider\*

The Gateways Community Services contact person will be: Carole Poulin  
Phone/extension: (603) 459-2705

**\*Please submit a respite reimbursement voucher by the 10th of each month following the month respite was provided (if applicable). Requests received after 30 days from date of respite will not be reimbursed.** The family must notify Gateways Community Services of their intent to use these funds. Failure to notify Gateways Community Services authorizes us to use the funding to help families in crisis.

If your child is between the ages of 16-21, they are eligible to receive high school transition services which may include: benefits support, attendance at IEPS, resource and referral, future planning, and access to adult service vendors that support a transition into the adult world.

- My child will participate in high school transition services.

Family Support Operations Manager: \_\_\_\_\_ Carole Poulin

Signature of Consumer/Parent/Guardian: \_\_\_\_\_ \*\*

Relationship to consumer: \_\_\_\_\_

Date: \_\_\_\_\_

**\*\*NOTE: Consumers over the age of 18 must sign for themselves unless there is a documented Power of Attorney or court-appointed legal guardian. Please enclose copy of P.O.A. or guardianship if not already on file with the Gateways Community Services.**

Service agreement  
9/7/11



**Family Support Information**

Consumer: \_\_\_\_\_ Date: \_\_\_\_\_

Client Code (For office use): \_\_\_\_\_ Gender: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Race (optional): \_\_\_\_\_ Primary Language: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Email: \_\_\_\_\_

May we send information (newsletters, calendar etc.), electronically? Yes  No

Email Address: \_\_\_\_\_

Primary Physician: \_\_\_\_\_

Primary Diagnosis: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

*(Healthy Kids Gold)*

NH Medicaid #: \_\_\_\_\_

Home Occupants:

Name	Relationship	Gender	Race*	Primary Language	Birth Date
1.					
2.					
3.					
4.					
5.					
6.					

*\*Race is optional*

Emergency Contact Information:

Contact	Work #	Mobile #	Email
1.			
2.			
3.			
4.			
5.			
6.			

**Please list who we may contact if we cannot reach the above listed persons**

Name			
Address			
City, State, Zip			
Home Phone:		Work Phone:	



## RESPIRE CARE PROFILE

Date: \_\_\_\_\_  
Name respite recipient: \_\_\_\_\_ DOB \_\_\_\_\_

Home Address: \_\_\_\_\_ Phone: \_\_\_\_\_

May we contact you by email? Y / N email address: \_\_\_\_\_

Parents/Legal Guardian Name: \_\_\_\_\_

Current Day Program: \_\_\_\_\_ Phone: \_\_\_\_\_

Siblings who provider might be responsible for: (names and DOB)  
\_\_\_\_\_  
\_\_\_\_\_

### *Behavior/Personality:*

____ Happy	____ Plays Alone	____ Hyperactive
____ Quiet	____ Follows Directions	____ Tantrums
____ Cries Often	____ Aggressive	____ Destructive

Explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Fears: \_\_\_\_ noises \_\_\_\_ dark \_\_\_\_ animals \_\_\_\_ others?

Explain: \_\_\_\_\_  
\_\_\_\_\_

Is he/she aware of personal safety? \_\_\_\_ yes \_\_\_\_ no

Hurts Self or Others (Please Describe): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Runs Away? \_\_\_\_ Precautions Taken: \_\_\_\_\_

Behavioral Information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Methods of Discipline: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Familiar Bedtime Routine: \_\_\_\_\_

List any rewards you may use for appropriate behaviors: \_\_\_\_\_

**Communication/Assistance:**

What is the primary language spoken in household? \_\_\_\_\_

How does he/she communicate? \_\_\_\_\_

\_\_\_\_\_ Words/sounds                      \_\_\_\_\_ Sign Language  
\_\_\_\_\_ Gestures/Expressions              \_\_\_\_\_ Augmentative Equipment

Does he/she have adaptive equipment for hearing/vision? \_\_\_\_\_

Does he/she have other adaptive equipment (mobility, eating)? \_\_\_\_\_

Does he/she need assistance with?

\_\_\_\_ Eating      \_\_\_\_ Stairs      \_\_\_\_ Walking      \_\_\_\_ Toileting      \_\_\_\_ Dressing      \_\_\_\_ Bathing

Foods/snacks not allowed: \_\_\_\_\_

Favorite Foods: \_\_\_\_\_

Food Allergies: \_\_\_\_ yes \_\_\_\_ no Explain: \_\_\_\_\_

Special Diets: \_\_\_\_ yes \_\_\_\_ no Explain: \_\_\_\_\_

Typical times for: Breakfast \_\_\_\_\_ Lunch \_\_\_\_\_ Dinner \_\_\_\_\_ Snacks \_\_\_\_\_

Household chores responsible to perform, please describe: \_\_\_\_\_

**Medical:**

Diagnosis(s): \_\_\_\_\_

Feeding Tube: \_\_\_\_ Manual      \_\_\_\_ Electric

Does he/she have seizures: \_\_\_\_ yes \_\_\_\_ no Type of Seizure: \_\_\_\_\_

Explain Warning Symptoms: \_\_\_\_\_

How long does seizure last? \_\_\_\_\_

What should provider do during and after seizure? \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone \_\_\_\_\_

**Recreation/Activities:**

Does he/she enjoy socializing with others? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, in what ways: \_\_\_\_\_

Does he/she enjoy being outside? Yes \_\_\_\_\_ No \_\_\_\_\_

Type of activities enjoys: \_\_\_\_\_

Any physical restrictions or limitations? \_\_\_\_\_

Does he/she enjoy being read to? Favorite books? \_\_\_\_\_

Indoor activities enjoys: \_\_\_\_\_

Recreational activities involved in (horseback riding, Special Olympics, Girl Scouts etc..) \_\_\_\_\_

**Respite Preferences:**

Respite Preferred: \_\_\_\_\_ In Home \_\_\_\_\_ In Community \_\_\_\_\_ Provider's Home  
Provider Smoking: \_\_\_\_\_ Permitted \_\_\_\_\_ Not Permitted \_\_\_\_\_ No Preference

Specific respite need? (Day of week/activity/hours?) \_\_\_\_\_

Can he/she be left home alone unsupervised? \_\_\_\_\_

Pets in the home: \_\_\_\_\_ cats \_\_\_\_\_ dogs \_\_\_\_\_ other

Names of pets & personality: \_\_\_\_\_

Any other information that would be helpful in caring for your child: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**GATEWAYS**  
COMMUNITY SERVICES

# Respite Reimbursement Voucher Form

Submit respite form to your account manager with specific dates respite was provided, including number of hours and the amount paid out.

**Requests must be submitted no later than 60 days after respite services occurred.**

**PARTICIPANT:**

(Only 1 consumer per form) FIRST \_\_\_\_\_ LAST \_\_\_\_\_

**ADDRESS:**

# AND STREET \_\_\_\_\_

CODE: \_\_\_\_\_

PHONE #: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

MONTH/YEAR: \_\_\_\_\_

TOWN/CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

DAYS OF MONTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
HRS. OF RESPITE RECEIVED																															
OFFICE USE ONLY																															

**Note:** Respite Reimbursements paid to an individual provider by you for services are taxable to that provider regardless of the payer. Under domestic employees Section 3121(x) of the Internal Revenue Code; the Social Security and Medicare wage threshold for household employees is \$1,700 for 2010. This means that if you pay a household employee cash wages of less than \$1,700 in 2010, you do not have to report and pay social security and Medicare taxes on that employee's 2010 wages. For more information, see *Social Security and Medicare wages in Publication 926, Household Employer's Tax Guide.* <http://www.irs.gov/publications/p926/index.html>

Gateways Community Services is not offering tax advice or guidance; each individual should consult their own tax professional for advice regarding their situation.

Hours: \_\_\_\_\_

Rate: \_\_\_\_\_

Total: \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_

DATE \_\_\_\_\_

**\*\* By signing this form you are stating that you have already paid for services rendered. \*\***

RETURN TO: Gateways Community Services, 144 Canal Street, Nashua, NH 03064 Attn: Respite  
Telephone: (603) 882-6333 Fax: (603) 889-5460

\*\*\*\* **Please submit respite reimbursement vouchers by the 10<sup>th</sup> of each month following the month respite was provided.** \*\*\*\*  
The Gateways Community Services reviews the usage of units each quarter and reserves the right to change your allocation during the year depending on usage, funding, availability of providers and family circumstances.



## Tax Information

Please contact your tax advisor for more information

TO: Parent, guardian or participant  
FROM: Tim Leach, Chief Financial Officer  
Gateways Community Services  
RE: Respite Reimbursement Tax Information  
DATE: April 2010

Gateways Community Services would like to update families that utilize RESPITE REIMBURSEMENT whether through Family Support or Consumer Directed Services. Respite means the provision of short-term care for an individual in and out of the individual's home for the temporary relief and support of the individual's family.

Respite Reimbursements paid to an individual provider *by you* for services are taxable to that provider **regardless** of the payer. This could have implications to you and the individual provider receiving the income for respite care services. Gateways Community Services is not offering tax advice or guidance; each individual should consult their own tax professional for advice regarding their situation.

Respite Care Services provided in the home could be defined by the IRS as Household Employees (domestic employees). Under domestic employees Section 3121(x) of the Internal Revenue Code; the Social Security and Medicare wage threshold for household employees is \$1,700 for 2010. This means that if you pay a household employee cash wages of less than \$1,700 in 2010\* or if you employ the services of more than one individual and pay total cash wages less than \$1,000 in any calendar quarter 2010 to household employees you do not have to report and pay social security and Medicare taxes on that employee's 2010\* wages.

For more information, see *Social Security and Medicare wages* in Publication 926, Household Employer's Tax Guide. Website: <http://www.irs.gov/publications/p926/index.html>

As of March 15, 2010 all Respite Reimbursement Forms will also display:

Respite Reimbursements paid to an individual provider by you for services are taxable to that provider regardless of the payer. Under domestic employees Section 3121(x) of the Internal Revenue Code; the Social Security and Medicare wage threshold for household employees is \$1,700 for 2010. This means that if you pay a household employee cash wages of less than \$1,700 in 2010, you do not have to report and pay social security and Medicare taxes on that employee's 2010 wages. For more information, see *Social Security and Medicare wages* in Publication 926, Household Employer's Tax Guide. <http://www.irs.gov/publications/p926/index.html> Gateways Community Services is not offering tax advice or guidance; each individual should consult their own tax professional for advice regarding their situation.

By signature of each Respite Reimbursement Form you take the responsibility to understand any tax liability regarding Respite Care Services. Updated Respite Reimbursement Forms are enclosed for your immediate use. If you have questions, please contact your Account Manager or Service Coordinator at (603) 882.6333.

Gateways Community Services felt that it was important to share this information. Please note: Gateways Community Services is not offering tax advice or guidance; each individual should consult their own tax professional for advice regarding their situation.

Rev March 4, 2010



## HC-CSD Medicaid

Home Care for Children with Severe Disabilities (HC-CSD), also known as Katie Beckett, is a Division of the Health and Human Services program designated to provide benefits to children under 18 years of age who have a severe disability or chronic illness.

### Did you know...

- Your child may be eligible for HC-CSD Medicaid if he or she has a developmental disability, sensory impairment, progressive or life threatening condition, behavioral disorder, mental illness, emotional disturbance or genetic disorder that requires ongoing medical monitoring.
- HC-CSD Medicaid only considers the child's income, not the family income. Savings accounts, mutual funds, bonds, certificates of deposit in the child's name as well as child support payments are all income belonging to the child.
- If you have private medical insurance HC-CSD Medicaid can act as your child's secondary insurance. Your child's pharmacy, dental and medical co-payments may be covered.
- Medicaid Health Insurance Premium Program (HIPP) may reimburse you for your child's portion of his or her private insurance premium. Under the HIPP program, the State pays a recipient's cost for group health insurance.
- HC-CSD Medicaid has a transportation reimbursement program. You may be eligible for mileage reimbursement to and from your child's medical appointments.
- If your child is age 3 or older and in disposable diapers or pull ups your child may be eligible to receive diapers or pull-ups from your local pharmacy or delivered right to your home free of charge.
- If you require a modification to your home or vehicle to help keep your child safe or to prevent injury to the caregiver Gateways Community Services may be able to assist you with an environmental modification.

These are just some of the benefits your child can receive through the New Hampshire HC-CSD Medicaid program. For more information or to apply, contact the Department of Health and Human Services district office at 1-800-852-0632 or 603-883-7726.



**CONSENT TO BILL**

**Client Name:** \_\_\_\_\_

**I hereby authorize Gateways Community Services to use or disclose health information that may be required to process a claim for payment of benefits. These benefits will be made payable to Gateways Community Services.**

**Client/Guardian's Signature:**

\_\_\_\_\_

**Medicaid #:**

\_\_\_\_\_

Buy a **TICKET** and have some fun!

*We are pleased to offer the following discount tickets:*

<b>Canobie Lake Park</b>	<b>Adult \$15.00</b>
<b>Water Country</b>	<b>Adult \$15.00</b>
<b>Story Land</b>	<b>\$10.00</b>
<b>Santa's Village</b>	<b>\$10.00</b>
<b>Chunky's</b>	<b>\$ 5.00</b>
<b>Cinemagic</b>	<b>\$ 5.00</b>
<b>SEE Science Center</b>	<b>\$2.50</b>



## The RULES

- ★ No Calls Please
- ★ Tickets available at Gateways Community Services on Monday's, from 2-4 p.m.
- ★ Cash only
- ★ First come, first serve
- ★ Maximum of 4 tickets per month, per family
- ★ Must be Family Support (FS), FS Consolidated, In-Home Support (IHS) or Adult Custom Services (ACS) and living with their family to be eligible.





The **PLUS COMPANY** Inc.  
*People • Learning • Useful • Skills*

September 1, 2011

Dear Parents/Family,

The PLUS Company provides a variety of supports and services to individuals with disabilities. We have an extensive Adult Education program which provides a variety of social, educational and recreational opportunities for adults.

The PLUS Company would like to begin offering similar type programs and activities for youth aged 16-21 years of age. In an effort to design a schedule that best meets the needs and interests of the youth and their families we are conducting a survey to obtain your feedback.

We would very much appreciate your input. Please complete the Youth Activities Survey and use the enclosed return envelope to Gateways Community Services. Gateways Community Services will forward all completed surveys to The PLUS Company.

Thank you,

Kim B. Shottes  
Executive Director  
The PLUS Company, Inc.

**Our Mission: Empower Individuals, Maximize Independence**

# PLUS COMPANY YOUTH ACTIVITIES SURVEY

August 2011

**Please check the activities which your son or daughter would be most interested in:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Movie Night     | <input type="checkbox"/> Life Skills Class | <input type="checkbox"/> Bingo             |
| <input type="checkbox"/> Arts and Crafts | <input type="checkbox"/> Exercise Class    | <input type="checkbox"/> Game Night        |
| <input type="checkbox"/> Cooking Class   | <input type="checkbox"/> Field Trips       | <input type="checkbox"/> Nutrition program |
| <input type="checkbox"/> Music Therapy   | <input type="checkbox"/> Yoga              | <input type="checkbox"/> Walking Program   |
| <input type="checkbox"/> Jazzercise      | <input type="checkbox"/> Performing Arts   | <input type="checkbox"/> Book Club         |
| <input type="checkbox"/> Bowling         |  |  |

**Are there additional activities not mentioned above you would like to see offered:**

**Days of Week most likely to participate (check all that apply):**

- |                                    |                                   |                                   |
|------------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Monday    | <input type="checkbox"/> Thursday | <input type="checkbox"/> Saturday |
| <input type="checkbox"/> Tuesday   | <input type="checkbox"/> Friday   | <input type="checkbox"/> Sunday   |
| <input type="checkbox"/> Wednesday |                                   |                                   |

**Time of Day most likely to participate (check all that apply):**

- |   |   |
|---|---|
| <input type="checkbox"/> Weekday Afternoons | <input type="checkbox"/> Weekend Afternoons |
| <input type="checkbox"/> Weekday Evenings   | <input type="checkbox"/> Weekend Evenings   |

**What would you consider a reasonable charge for your son or daughter to participate in an activity?**

- |                                    |                                    |                                  |
|------------------------------------|------------------------------------|----------------------------------|
| <input type="checkbox"/> \$15-\$20 | <input type="checkbox"/> \$20-\$25 | <input type="checkbox"/> \$25-30 |
|------------------------------------|------------------------------------|----------------------------------|

(Please note depending upon the support needs required there may be an additional cost to participate.)

**Optional: (if you would like to receive more information about opportunities offered by PLUS for young adults.)**

Name \_\_\_\_\_  
Email Address \_\_\_\_\_  
Phone Number \_\_\_\_\_

For more information about The PLUS Company, Inc. please visit our website at [www.pluscompany.org](http://www.pluscompany.org)

**Empowering Individuals, Maximizing Independence**