

**Special Needs Respite Application**  
Family Support Services - Catholic Charities Disabilities Services  
1 Park Place Suite 200 Albany NY 12205 (518) 783-1111

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Name of Individual: \_\_\_\_\_ Date Submitted: \_\_\_\_\_

Area of High Need:  Medical  Behavioral  Both Dollar Amount Requested: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Medicaid Number: \_\_\_\_\_ Soc. Sec. Number: \_\_\_\_\_

County of Residence: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name of Parent and/or Legal Guardian: \_\_\_\_\_

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

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Name/Relationship of Person Submitting Application: \_\_\_\_\_

Address of Person Submitting Application: \_\_\_\_\_

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Phone Number of Person Submitting Application: \_\_\_\_\_

**Please answer all questions thoroughly:**

**1. Has a DDP-4 been completed to indicate the need for Respite services?**

Yes  No  Unsure

**2. What is the Individual's Developmental Disability?**

Mental Retardation  Epilepsy  Autism  Cerebral Palsy

Neurological Impairment Please Specify: \_\_\_\_\_

Other Please Specify: \_\_\_\_\_

**3. Has the individual applied for/been approved for FSS Respite funds through CCDS or any other agency this year?  yes  no Please list agencies, and indicate amount applied for or approved:**

Agency:	Amount applied for:	Amount approved:
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**4. Please indicate any services this individual is receiving at this time:**

<b>Type of Service</b>	<b>Agency Providing Service</b>	<b>Contact Person and Phone Number</b>	<b>How often is this service currently being provided?</b>
<b>Early Intervention</b>			
<b>Medicaid Service Coordination</b>			
<b>Residential Habilitation</b>			
<b>Waiver In Home Respite</b>			
<b>Free standing Out of Home Respite</b>			
<b>School</b>			
<b>Day Program</b>			
<b>Other</b>			

**5. Please describe the individual's developmental disability in terms of the care and supervision they require:**

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**6. Please describe who lives in the home (is this a single parent family, number of siblings, does anyone else in the home have a disability)?**

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**7. Please describe the individual's area of high need (Behavioral/Medical/Both), and how it effects the person ability to function within the family and in their daily environment:**

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**8. Is this family in crisis?** Yes No **If so, please explain:**

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**9. Is this a single parent family?** Yes No

**10. Is there a provider designated to provide this service?** Yes No

**11. If approved, how will the funds be used? (Please circle the letter(s) of all choices that apply)**

- A. Increasing utilization of existing OMRDD Waiver Respite funds by supplementing the current pay rate
- B. Providing an additional Respite staff person (2:1 staffing)
- C. Employing an FSS Respite provider at an increased rate
- D. Phone consultation with a Behaviorist
- E. The family may employ a Nurse

**12. Please indicate yearly income of family and number of people living in the home:**

- \$0-\$25,000 \$26,000 - \$35,000 \$36,000 - \$45,000 \$46,000 - \$55,000  
\$56,000 - \$65,000 \$65,000 - \$80,000 Other \$ \_\_\_\_\_

\_\_\_\_**Number of people living in the home**

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**THANK YOU FOR TAKING THE TIME TO THOROUGHLY COMPLETE THIS APPLICATION.**

Please understand that our committee receives many applications from families who are in need of Respite Reimbursement. We review each application very carefully and approve funds for as many families as we can. You should expect to hear from us soon after our scheduled meeting regarding the results of your application.

**If the applicant is approved for funds to hire a nurse or consultation with a behaviorist, a list of nursing agencies and behaviorists will be supplied to the family. However, they may hire anyone they wish to provide this service.**

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**Instructions:**

**A. Description of grant:** Catholic Charities Disabilities Services Family Support Services Special Needs Respite provides financial assistance to families who are in need of Respite Services and are caring for a family member with high behavioral or medical needs along with a developmental disability and limited resources who live in the following counties: Albany, Rensselaer, Schenectady, Schoharie, Saratoga, Fulton, Montgomery, Warren and Washington counties. The family will keep track of Respite and Behaviorist hours, fill out a provider log, submit the log, receive a check from CCDS, and then pay the provider. Families will locate and hire their own providers. A maximum of \$1,000.00 per year may be requested per consumer.

**B. Respite funds can be used in any of the following ways:**

1. **Increasing utilization of existing OMRDD Waiver Respite funds by supplementing the current pay rate:** For example, if the person currently has approved Respite hours through the OMRDD Waiver at a pay rate of \$9 per hour, but no one is willing to provide the service because of the nature of the behaviors the person displays, the grant could pay \$6 per hour on top of the \$9 per hour from the Waiver to equal a pay rate of \$15 per hour. It is much more enticing for staff to receive \$15 per hour to do a job they wouldn't normally do for lower pay. The side benefit to this is that existing services would be utilized, and the grant money would be stretched further.
2. **Providing an additional Respite staff person (2:1 staffing):**  
This choice also has the side benefit of utilizing the existing Waiver Respite service. Families would have a choice of hiring an additional Respite provider at a hourly rate determined by the family, to have 2 staff to work with one consumer. This is often needed when a person has a lot of behaviors and wants to go out into the community. The rate of pay through the Waiver may be \$9/hr for that staff, but they'd be more willing to work with the person because they would have another staff to assist them in case the consumer bolted, dropped, had an outburst or tantrum etc. Or, for someone with high medical needs, they could safely go out into the community, especially if they need a two person transfer.
3. **Employing an FSS Respite provider at an increased rate:**  
This choice would enable the family of someone with a great deal of behaviors to pay a higher rate (\$15/hr) to a provider for Respite. This is especially helpful to families whose child is not currently approved for Waiver Respite.
4. **Phone consultation with a Behaviorist:**  
Families who have a child with a great deal of behaviors often feel stressed out and burnt out. They aren't receiving respite because no one wants to provide the service, and they don't have the time or resources to join a support group or go to counseling. This service will be available to approved applicants. There will also be money set aside from the grant to provide funding for this service. It will be billed by quarter hour. A list of certified behaviorist and phone numbers will be presented to the families along with the approval letter regarding their application. The pay rate will be \$25 per hour, or \$6.25/quarter hour.
5. **The family may employ a Nurse:**  
Many families of children with high medical needs lack Respite because they are unwilling to leave their child with an untrained provider. The family would be able to privately hire a nurse with the money approved to them through this grant. A list of nursing agencies will be provided to families along with the approval letter regarding their application.

## **Special Needs Respite**

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### **C. Please submit the following information along with the completed application:**

1. **DDP-1 indicating the addition of FSS Respite through CCDS** (we will add the code and start date if approved).
2. **DDP-4 indicating the need for Respite Services.**
3. **OMRDD Letter of Eligibility** (if Provisional Eligibility letter is submitted it must be current). If the letter is not submitted the application cannot be processed
4. **Documentation or Diagnosis indicating area of high medical or behavioral need:**  
Documentation may include, but is not limited to a behavior plan, IEP, nursing notes/plan, ISP, Doctor note, physical form, psychological evaluation.

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### **D. Send the completed application packet (Application, DDP-1, DDP-4, Documentation of Developmental Disability and Documentation of Diagnosis indicating Medical or Behavioral Need) to:**

Catholic Charities Disabilities Services  
Attention: Amie Anderson  
FSS- Special Needs Respite  
1 Park Place, Suite 200 Albany NY 12205

## DEVELOPMENTAL DISABILITIES PROFILE REGISTRATION / MOVEMENT FORM

Fill in the blanks or mark the appropriate number for each shaded item. Complete other items as required.

1	PURPOSE:	<input type="checkbox"/> 1 Demographic Data Change	<input type="checkbox"/> 3 Moved Out of State	<input type="checkbox"/> 5 Died															
		<input type="checkbox"/> 2 Add	<input type="checkbox"/> 4 Remove	<input type="checkbox"/> 6 Transferred within agency															
2	TAB ID: <i>(if known)</i>																		
3	PERSON'S NAME	LAST	FIRST	MI															
4	SEX:	<input type="checkbox"/> 1 MALE	<input type="checkbox"/> 2 FEMALE	5															
6	COUNTY OF RESIDENCE:	DATE OF BIRTH: MO DAY YR																	
7	AGENCY NAME:	PROGRAM NAME:																	
8	REMOVE PROGRAM CODE:	9 ADD PROGRAM CODE:																	
10	REMOVE / ADD DATE:	MO	DAY	YR															
11	RESIDENTIAL ADDRESS: % <i>(please print)</i>	NAME																	
		STREET																	
		CITY STATE ZIP																	
12	INDIVIDUAL'S RESIDENCE TYPE: <i>(mark only one)</i>	<input type="checkbox"/> 1 Alone <input type="checkbox"/> 4 Department of Social Services Residence or Foster Care Home <input type="checkbox"/> 7 OMRDD / Agency Operated Residence <input type="checkbox"/> 2 With Friends / Housemates <input type="checkbox"/> 5 Nursing Facility <input type="checkbox"/> 8 Other <i>(specify)</i> _____ <input type="checkbox"/> 3 With Member of His / Her Own Family <input type="checkbox"/> 6 Homeless or Shelter																	
13	SOCIAL SECURITY NUMBER:	14	PERSON'S MEDICAID NUMBER (CIN):																
15	ETHNICITY / RACE:	<input type="checkbox"/> 1 White <input type="checkbox"/> 3 Hispanic <input type="checkbox"/> 5 American Indian / Alaskan <input type="checkbox"/> 2 Black <input type="checkbox"/> 4 Asian or Pacific Islander <input type="checkbox"/> 6 Other																	
16	DISABILITIES: Indicate "1" for Primary (mark only one) and "2" for All Other Disabilities: (mark as many as apply)																		
	<input type="checkbox"/> 1 Developmental Delay	<input type="checkbox"/> 8 Psychiatric Disability	<input type="checkbox"/> 15 Fetal Alcohol Syndrome																
	<input type="checkbox"/> 2 Mental Retardation	<input type="checkbox"/> 9 Chronic Physical / Medical Condition	<input type="checkbox"/> 16 Narcolepsy																
	<input type="checkbox"/> 3 Autism	<input type="checkbox"/> 10 Sensory Impairment	<input type="checkbox"/> 17 Neurofibromatosis																
	<input type="checkbox"/> 4 Cerebral Palsy	<input type="checkbox"/> 11 Undetermined	<input type="checkbox"/> 18 (Code Not Valid at this Time)																
	<input type="checkbox"/> 5 Epilepsy / Seizure Disorder	<input type="checkbox"/> 12 Other <i>(specify)</i> _____	<input type="checkbox"/> 19 Spina Bifida																
	<input type="checkbox"/> 6 Learning Disability	<input type="checkbox"/> 13 Traumatic Brain Injury (TBI)	<input type="checkbox"/> 20 Tourette Syndrome																
	<input type="checkbox"/> 7 Other Neurological Impairment	<input type="checkbox"/> 14 Prader-Willi Syndrome (PWS)	<input type="checkbox"/> 21 Toxic Substance Exposure																
		<input type="checkbox"/> 22 Child Under 5 Unable to Diagnose																	
17	PREFERRED LANGUAGE:	<table style="width: 100%; border: none;"> <tr> <td style="width: 33%;"><b>Spoken</b></td> <td style="width: 33%;"><b>Nonverbal</b></td> <td style="width: 33%;"><b>Understood</b></td> </tr> <tr> <td><input type="checkbox"/> 1 English</td> <td><input type="checkbox"/> 1 Sign</td> <td><input type="checkbox"/> 1 English</td> </tr> <tr> <td><input type="checkbox"/> 2 Spanish</td> <td><input type="checkbox"/> 2 Other Symbolic</td> <td><input type="checkbox"/> 2 Spanish</td> </tr> <tr> <td><input type="checkbox"/> 97 None</td> <td><input type="checkbox"/> 97 None</td> <td><input type="checkbox"/> 97 None</td> </tr> <tr> <td><input type="checkbox"/> 98 Other _____</td> <td><input type="checkbox"/> 98 Other _____</td> <td><input type="checkbox"/> 98 Other _____</td> </tr> </table>			<b>Spoken</b>	<b>Nonverbal</b>	<b>Understood</b>	<input type="checkbox"/> 1 English	<input type="checkbox"/> 1 Sign	<input type="checkbox"/> 1 English	<input type="checkbox"/> 2 Spanish	<input type="checkbox"/> 2 Other Symbolic	<input type="checkbox"/> 2 Spanish	<input type="checkbox"/> 97 None	<input type="checkbox"/> 97 None	<input type="checkbox"/> 97 None	<input type="checkbox"/> 98 Other _____	<input type="checkbox"/> 98 Other _____	<input type="checkbox"/> 98 Other _____
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<input type="checkbox"/> 98 Other _____	<input type="checkbox"/> 98 Other _____	<input type="checkbox"/> 98 Other _____																	
18	DATE COMPLETED:	MO	DAY	YR															
COMPLETED BY: <i>(Print staff name)</i>			PHONE NUMBER: (      ) _____ - _____																

**The DDP-1 is to be completed by all voluntary agency OMRDD-certified or funded programs or services.  
Private schools may use either form DDP-1 or OMR 725.**

**GENERAL INSTRUCTIONS:**

Items 1-7 and 18 should **always** be completed.

Complete items 8 and 10 if a person is leaving a program or 9 and 10 if a person is entering a program.

Complete items 8, 9 and 10 if purpose #6, Transferred within agency, is marked.

Complete items 11-17 for anyone new to your agency, for anyone not previously registered in TABS, or if there is a question about whether a person has been previously registered in TABS.

**1. Purpose:**

- 1 Select this response if information on a **previous** form should be updated or corrected.
- 2 A person is added to a residence on the first day he/she sleeps in the residence. A person is added to a day program/service on the first day he/she receives services.
- 4 If a person is leaving more than one program within the agency, each program must report the removal of that person from its rolls.
- 5 The date of the person's death should be entered in item 10, *Remove/Add Date*.
- 6 Select this response if a person is changing programs (such as a residence) within the same agency. Complete items 8, 9 and 10 if this purpose is chosen.

**2. TABS ID:**

The minimum information required to register a person in TABS is the person's name, sex, date of birth, and county of residence. This number may be up to 6 digits in length.

**3. Name and 5. Date of Birth:**

For each of these items, use the person's birth certificate as the preferred source of the information. If not available, use the information as it appears on the person's Medicaid card.

**6. County of Residence:**

This is the name of the county where the person resides. If adding this person to a residential program, use the name of the county where the residence is located.

**8.& 9. Program Code (Remove & Add):**

The Program code is an eight (8) digit number used to identify the program or service in TABS. Please contact the DDP Coordinator in your area if you are unsure of the correct code to use.

**10. Remove/Add Date:**

Enter the date of the event for choice 2-6 in item 1, *Purpose*. Enter a date if choice 1, *Demographic Data Change*, involves a change of address.

**16. Disabilities:**

Any disability indicated in this item should be officially documented in the person's record including the signature of the diagnosing physician or psychologist.

**17. Preferred Language:**

Indicate which method of communication the person **prefers** to use.

**18. Completed by:**

This should contain the name and phone number (including area code) of the **staff** person who has completed this form. *Please do not ask a parent, guardian or friend to complete the DDP-1.*

If you have other questions about any item on the DDP-1, please consult the Users Guide.  
Copies of the Guide may be obtained from your DDP Coordinator.