

Catholic Charities Disabilities Services  
Family Reimbursement Grant For Respite Funds  
1 Park Place, Suite 200 Albany, NY 12205  
(518) 783-1111

**Instructions (Please read thoroughly prior to completing application):**

Catholic Charities Disabilities Services Respite Grant provides financial assistance to families who are in need of Respite Services living in the following counties: ***Albany, Rensselaer, Schenectady, Schoharie, Saratoga, Fulton, Montgomery, Warren & Washington counties.*** For the purpose of this grant, **Respite is defined as the in home care of a person with a disability in order to provide parents/caregiver with a break that they would not otherwise have.** Please note the following:

- We are not able to provide assistance for daily child care expenses during parents' work hours, unless there are time-limited, emergency circumstances. (In this case, please call to discuss prior to submitting an application).
- We are not able to consider requests for camp expenses or activity expenses under any circumstances.

Families who submit applications for this service and who have been notified that they are approved for Respite Reimbursement, are responsible for hiring their own provider and scheduling Respite with that provider. Documentation that the Respite was provided is submitted to us. At that point reimbursement is provided to the family for costs incurred.

Requests can be made for up to \$500 per individual per calendar year. If there are exceptional circumstances, requests beyond \$500 may be considered. In this case, please contact the family reimbursement coordinator to discuss these circumstances.

To be considered for Respite Reimbursement, **please submit the following along with the completed application:**

- **All questions must be answered completely to have the application considered for approval.**
- **DDP-4 indicating the need for Respite Services**
- **DDP-1 indicating the addition of FSS Respite through CCDS (we will add the code and start date if approved).**
- **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.**
- **Updated ISP**

Please send the completed application to:

Family Reimbursement Program – Attention: Amie Anderson  
Catholic Charities Disabilities Services  
1 Park Place, Suite 200  
Albany, NY 12205

Or Fax the application to (518) 785-4894 – Attention: Amie Anderson

Catholic Charities Disabilities Services Family Reimbursement  
Grant for Respite Funds

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

Dollar Amount Requested: \_\_\_\_\_

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

Medicaid Number: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

County of Residence: \_\_\_\_\_

Phone Number: \_\_\_\_\_

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

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

Is the family/child of Hispanic Descent? Yes  No

(This program was created with the needs of this underserved population in mind)

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

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

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

Relationship to the Person with Disability: \_\_\_\_\_

**Please answer all questions completely and with as much detail as possible.**

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

Yes  No  Unsure

***\*\*A DDP-4 indicating that the individual has a need for Respite, must be completed and submitted to the DDSO in order for us to review the application. If a DDP-4 has been completed, please attach a copy to this application. If a DDP-4 has not been completed we will complete one on your behalf.***

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

Mental Retardation Epilepsy Autism Cerebral Palsy

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

Other **Please Specify and describe the disability (doctor reports may be submitted to help describe the disability if necessary):**

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

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 all services individual is receiving at this time (must be filled out completely)

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

5. Please describe the individual's disability in terms of the care and supervision they require from others (please be as descriptive as possible):

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6. Please describe who lives in the home. Are there any unique circumstances about the family situation that you would like to share with us? (ex. Is this a single parent family? Is there anyone else in the home with a disability? etc.)

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7. Name all immediate family members who provide care for the individual at this time.

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8. Are there other family members or friends living outside the home who provide care or assistance with care?

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9. If this is a single parent family, is the other parent involved in the care of the individual?

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10. Is this family in crisis?  Yes  No If so, please explain the nature of the crisis:

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11. If funds are approved, how will the funds be used (question must be answered thoughtfully and thoroughly)?

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12. If funds are approved, is there a provider designated to provide this service (this question must be answered)?  Yes  No

13. Please indicate yearly income of the family and number of people living in the home (question must be completed):

\$0-\$29,999  \$30,000-\$59,000  \$60,000-\$99,000  \$100,000 or above

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

**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.

The meeting schedule for the year is attached.

You should expect to hear from us soon after our next meeting regarding the results of your application.

## 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:<br><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: %<br><i>(please print)</i>  | NAME   |  |  |
|    |  | STREET   |  |  |
|    |  | CITY   |  |  |
|    |  | STATE  |  | ZIP  |
| 12 | INDIVIDUAL'S RESIDENCE TYPE: <i>(mark only one)</i>  | <input type="checkbox"/> 1 Alone<br><input type="checkbox"/> 2 With Friends / Housemates<br><input type="checkbox"/> 3 With Member of His / Her Own Family<br><input type="checkbox"/> 4 Department of Social Services Residence or Foster Care Home<br><input type="checkbox"/> 5 Nursing Facility<br><input type="checkbox"/> 6 Homeless or Shelter<br><input type="checkbox"/> 7 OMRDD / Agency Operated Residence<br><input type="checkbox"/> 8 Other <i>(specify)</i> _____ |  |  |
| 13 | SOCIAL SECURITY NUMBER:  | 14 PERSON'S MEDICAID NUMBER (CIN):   |  |  |
| 15 | ETHNICITY / RACE:  | <input type="checkbox"/> 1 White<br><input type="checkbox"/> 2 Black<br><input type="checkbox"/> 3 Hispanic<br><input type="checkbox"/> 4 Asian or Pacific Islander<br><input type="checkbox"/> 5 American Indian / Alaskan<br><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:  | <b>Spoken</b><br><input type="checkbox"/> 1 English<br><input type="checkbox"/> 2 Spanish<br><input type="checkbox"/> 97 None<br><input type="checkbox"/> 98 Other _____   |  |  |
|    |  | <b>Nonverbal</b><br><input type="checkbox"/> 1 Sign<br><input type="checkbox"/> 2 Other Symbolic<br><input type="checkbox"/> 97 None<br><input type="checkbox"/> 98 Other _____  |  |  |
|    |  | <b>Understood</b><br><input type="checkbox"/> 1 English<br><input type="checkbox"/> 2 Spanish<br><input type="checkbox"/> 97 None<br><input type="checkbox"/> 98 Other _____   |  |  |
| 18 | DATE COMPLETED:  | MO   | DAY  | YR   |
|    | COMPLETED BY: <i>(Print staff name)</i>  | PHONE NUMBER:<br>( ) _____ - _____   |  |  |

**Catholic Charities Disabilities Services  
Family Reimbursement Meeting Schedule  
2010**

**January 26, 2010 (committee meeting)**

**Applications due by Friday, January 22<sup>nd</sup>**

**April 27, 2010 (committee meeting)**

**Applications due by Friday, April 23<sup>rd</sup>**

**July 27, 2010 (committee meeting)**

**Applications due by Friday, July 23<sup>rd</sup>**

**October 26, 2010 (committee meeting)**

**Applications due by Friday, September 22<sup>nd</sup>**

**FSS GRANT APPLICATIONS RECEIVED AFTER THE QUARTERLY DUE DATE WILL BE  
SUBMITTED FOR THE FOLLOWING QUARTERLY COMMITTEE MEETING DATE.**

**Please contact Amie Anderson at 783-1111 ext. 225 or [amiea@ccdservices.org](mailto:amiea@ccdservices.org).**