

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).
- Documentation of a Developmental Disability:
 - *For MSC or HCBS Waiver Enrolled Individuals:* a copy of the Notice of Decision for either of these programs is sufficient
 - *For Those Not Enrolled in MSC or the HCBS Waiver:* a recent Psychological and Adaptive Behavior Scale is most often needed to determine OMRDD eligibility. Please send and information that you have relating to the individual's disability. We will review I and contact you if more information is needed. The information provided will be passed along to OMRDD for eligibility determination.

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:

4. Please indicate all services individual is receiving at this time:

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			

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

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.

Catholic Charities Disabilities Services
2007 Family Reimbursement Meeting Schedule

January 23, 2007 10:00 am
Applications are due Thursday 1/18/07 by noon

March 13, 2007 10:00 am
Applications are due Thursday 3/8/07 by noon

June 12, 2007 10:00 am
Applications are due Thursday 6/7/07 by noon

September 11, 2007 10:00 am
Applications are due Thursday 9/6/07 by noon