Family Support Services – Special Needs Grant
Special Needs Reimbursement Log

Name of Individual with Disability:_____

There is no set rate for the Special Needs Respite. Families will agree upon the rate along with the Respite Provider they hire. Families are required to keep track of the time by the hour and make payment arrangements with the provider.
***Options for use of Respite funds:**

- **A) Increasing Utilization of existing Waiver Respite funds 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**

Date	Name of Provider	# of Hours	Pay Rate	Amount Paid	Note which option was used (SEE ABOVE A,B,C)	Provider Signature	Parent Signature

Total Respite Hours = _____ Total Amount Paid = _____

Name of family member to whom the check should be written:

Name:_____
Address:_____
City, State, Zip:_____
Phone Number:_____

Please submit To: Catholic Charities Disabilities Services
Family Reimbursement: Amie Anderson
1 Park Place, Suite 200
Albany, NY 12205