

**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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### **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.

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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. **Documentation of a Developmental Disability:** *For MSC or HCBS Waiver Enrolled Individuals:* a copy the Approval letter or Notice of Decision is sufficient. *For those not yet enrolled in MSC or the HCBS Waiver:* you may send a recent psychological, Adaptive Behavior Scale, physical form indicating disability, etc.
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  
FSS- Special Needs Respite  
1 Park Place, Suite 200 Albany NY 12205

#### **Tenative 2007 Family Reimbursement Committee Schedule**

January 19, March 16, June 15 and September 21 (10 a.m. to 2 p.m.)  
A November meeting will be scheduled if funds are available.