Catholic Charities Disabilities Services'
2021 Family Reimbursement Grant for Goods and Services or Respite
(Formerly HOS FSS)
1 Park Place, Suite 100, Albany, NY 12205
(518) 783-1111

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

Family Reimbursement, formerly provided through ***Hispanic Outreach Services*** will continue under ***Catholic Charities Disabilities Services***. The program will continue to provide the same supports in ***Albany, Rensselaer, Schenectady, Schoharie, Saratoga, Fulton, Montgomery, Warren and Washington counties***.

This grant provides financial assistance to families who are in need of respite services or funding for certain goods or services that are necessary *to support the individual with the developmental disability*. Because these funds are limited and very precious to so many families, it is expected that such funds requested through this grant cannot be provided through any other resource (Insurance, Public Assistance, HEAP, etc.), and that the Care Manager **has** exhausted those possibilities.

FSS Reimbursement Guidelines

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.

Families who submit applications who have been notified that they are approved for a good or service are responsible for making the purchase and submitting the original detailed receipt to us for reimbursement. If there are circumstances preventing you from doing this, other arrangements can possibly be made. We encourage you to consider options such as on-line purchasing and direct payments if needed. Please note that we are unable to disburse cash payments in advance.

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 Support Services Coordinator to discuss these circumstances. Consideration will be given to individuals who have not previously accessed funds from this grant in the year.

To be considered for reimbursement, **please submit a completed application with ALL the required documentation below** . Please note that all questions must be answered completely to have the application considered for approval. The individual must be a resident of one the counties listed above and live at home with his/her family.

Please initial next to the items included with your application.

☐ **OPWDD Letter of Eligibility- If the Provisional Eligibility letter is submitted it must be current. If the Letter of Eligibility is not submitted the application cannot be processed.**

☐ **Current Life Plan -** *Please highlight information which may be particularly helpful for the committee to review in relation to your request.*

☐ **Completed "Acknowledgment and Consent" Form giving permission for CCDS Staff to contact other agencies regarding this request.**

☐ **Current IEP (if it supports the request) -** *Please highlight information which may be particularly helpful for the committee to review in relation to your request.*

☐ **Self-Direction Budget (if plan has launched)**

☐ **Denial from Medicaid/Insurance (if applicable)**

☐ **Three estimates (if applicable)**

☐ **Psychological Evaluation (if applicable) -** *Please highlight information which may be particularly helpful for the committee to review in relation to your request.*

Please send the completed application to:

Family Support Services – Attention: Beth Cassidy
Catholic Charities Disabilities Services
1 Park Place, Suite 100
Albany, NY 12205

Or Fax the application to (518) 785-4894 – Attention: Beth Cassidy, Family Support Services or email the application via secure email to bethc@ccdservices.org

Catholic Charities Disabilities Services
2021 Family Reimbursement Grant for Goods and Services or Respite (Formerly HOS FSS)

Name of Individual: Date Submitted:

Name of Parent and/or Legal Guardian:

Address:

Phone Number: TABS #:

County of Residence: Albany ○ Fulton ○ Montgomery ○ Warren ○

Rensselaer ○ Saratoga ○ Schenectady ○ Schoharie ○ Washington ○

Date of Birth: Age:

Is the Individual Waiver Enrolled?

Medicaid Info: Number: County

Is Medicaid the individual's Primary Insurance?

**If no, please list all other insurances:

Is the family/child of Hispanic Descent? Yes ○ No ○
(This grant evolved from an agency whose ambition and existence was to assist individuals of Hispanic origin)

Dollar Amount Requested:

***Please ensure that the dollar amount requested is actually what can be used in 2021, if approved.*
If funds are approved, how will the funds be used (question must be answered thoughtfully and thoroughly)?

Name of Person Submitting Application:

Complete Address :

Phone Number of Person Submitting Application:

Email Address of Person Submitting Application:

Relationship to the Person with Disability:

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

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

☐ Intellectual Disability ☐ Epilepsy ☐ Autism ☐ Cerebral Palsy ☐ Down Syndrome

☐ Medical Diagnosis ☐ Neurological Impairment – Please Specify: ☐

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

2. **Has the individual applied for/been approved for FSS funds through CCDS or any other agency this year? ○ Yes ○ No Please list agencies, and indicate amount applied for, approved, and the item/service requested, i.e. respite, a specific good/service, etc.**

Agency:	Amount Applied for:	Amount approved:	Item/Service Requested:

3. **Is the applicant currently applying elsewhere with this same request?**

Yes ○ No ○

Please note, by signing the Acknowledgment and Consent at the end of this application, you give permission for CCDS staff to contact other agencies regarding your reimbursment requests.

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, i.e. 4 hrs/wk?
Early Intervention			
Care Coordination			
Community Habilitation			
Waiver In-Home Respite			

Type of Service	Agency Providing Service	Contact Person and Phone Number	How often is this service currently being provided?
Self-Directed Services (Contact: Broker)			
Free Standing Out of Home Respite			
School			
Day Program			
Afterschool Program			
Personal Care Aide or Consumer Directed Service			
Other			

5. **Are the services listed under #4 sufficient in meeting the individual's/family's needs? If no, please explain.**

6. **Please describe the individual's disability in terms of the care and supervision they require from others (<u>please be as descriptive as possible</u>):**

7. **Please <u>list all individuals who reside in the home</u> . Are there any unique circumstances about the family situation that you would like to share with us that further supports the need for this request? (ex. Is this a single parent family? Is there anyone else in the home with a disability? etc.)**

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

9. **Is this family in crisis? ◯ Yes ◯ No If yes, please explain the nature of the crisis.**

10. **Is this family lacking support from family and friends (please answer for respite applicants)?**

11. **If respite funds are approved, is there a provider designated to provide this service (<u>this question must be answered</u>)? ◯ Yes ◯ No ◯ N/A (G/S app)**

12. **Please indicate yearly income of the family and number of people living in the home (question must be completed). <u>*Please only list wages from employment.*</u>**

    $ _____ / per year

    ____ Number of people living in the home ____ adults ____ children

13. **Please indicate what other financial supports the individual and/or family is receiving.** ******Please include amount received per month, per year, and then total.***

	Monthly Amount	Annual Amount
Food Stamps		
SSI		
SSDI		
HEAP		
Public Assistance		
Housing Assistance (HUD, Section 8, etc.)		
Child Support		
Survivor's Benefits		
Other- please specify		
TOTAL		

14. **If you are requesting reimbursement for a good or service, please indicate what other avenues have been explored/exhausted for funding. Please be as specific as possible.**

15. **Has the individual been approved for Self-Direction Services?**

Yes ○ **No** ○ **N/A** ○

16. **Has the Self-Direction Plan launched?**

Yes ○ **No** ○ **N/A** ○

****If Yes, please attach a copy of the Self-Direction Budget!**

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 and/or funds for Goods and Services 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 next meeting regarding the results of your application.

*****Please note that incomplete applications will not be reviewed and will hold up the approval process for the individual in need. Applications received after the deadline will be held until the following meeting.***

CATHOLIC CHARITIES DISABILITIES SERVICES'

GOODS/SERVICES PROGRAM

2021 Meeting Schedule

January 26, 2021
Applications due by January 12, 2021

March 30, 2021
Applications due by March 16, 2021

May 18, 2021
Applications due by May 4, 2021

July 20, 2021
Applications due by July 6, 2021

September 21, 2021
Applications due by September 7, 2021

November 9, 2021
Applications due by October 26, 2021

Acknowledgement and Consent

By signing below, I give permission for CCDS staff to contact other agencies regarding this reimbursement request.

_____

Signature of Individual or Personal Representative

Print Name of Individual or Person Representative

Date

Description of Personal Representative's Authority