Catholic Charities Disabilities Services
2021 Family Reimbursement Grant For Respite Funds
1 Park Place, Suite 100, Albany, NY 12205
(518) 783-1111

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

Catholic Charities Disabilities Services' Respite Reimbursement 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***. Families are eligible if they have a family member with a developmental disability who lives at home. Please note that 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 Support Services Coordinator to discuss these circumstances.

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

- Eligibility Approval Letter from OPWDD (If 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 "Acknowledgement and Consent" Form giving permission for CCDS Staff to contact other agencies regarding this request.
- Self Direction Budget (if plan has launched)

Please send the completed application/attachments 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 or email the application via secure email to bethc@ccdservices.org

Catholic Charities Disabilities Services Family
Reimbursement Grant for Respite Funds
(2021)

Name of Individual: Date Submitted:

Dollar Amount Requested: TABS #:

Date of Birth: Age:

Medicaid Number:

County of Residence:

Phone Number: Is the Individual Waiver enrolled?

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:

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):**

****Please ensure that the dollar amount requested is actually what can be used in 2021, if funds are approved.**

2. **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:

3. **Is the applicant currently applying elsewhere with this same request: ◯ Yes ◯ No**
   Please note, by signing the Acknowledgement and Consent at the end of this application, you give **permission** for CCDS staff to contact other agencies regarding your reimbursement requests.

4. **Please indicate all services the 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, i.e. 4hrs/wk?**
Early Intervention			
Care Coordination			
Community Habilitation			
Waiver In Home Respite			
Free Standing Out of Home Respite			
Self-Directed Services (Contact: Broker)			
School			
Day Program			
Afterschool Program			
Personal Care Aide or Consumer Directed Services			

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 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.)**

8. **Is this family lacking support from family and friends?**

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

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

11. **If funds are approved, is there a provider designated to provide this service (<u>this question must be answered</u>)? ○ Yes ○ No**

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

Yes ◯ **No** ◯ **N/A** ◯

15. 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 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.

<u>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.</u>

CATHOLIC CHARITIES DISABILITIES SERVICES

RESPITE REIMBURSEMENT PROGRAM

2021 MEETING SCHEDULE

FEBRUARY 11, 2021
APPLICATIONS DUE JANUARY 28, 2021

MAY 6, 2021
APPLICATIONS DUE APRIL 22, 2021

AUGUST 5, 2021
APPLICATIONS DUE JULY 22, 2021

NOVEMBER 18, 2021
APPLICATIONS DUE NOVEMBER 4, 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