CCDS' 2021 Special Needs Respite Application

Family Support Services - Catholic Charities Disabilities Services
1 Park Place, Suite 100, Albany NY 12205, (518) 783-1111

Name of Individual: _____ **Date Submitted:** _____

Check Area of High Need: Please choose an option: **Dollar Amount Requested:** _____

Date of Birth: _____ **Age:** _____ **TABS #:** _____

Medicaid Number: _____ **Phone Number:** _____

County of Residence: _____

Is the Individual Waiver Enrolled? _____

Address: _____

Name of Parent and/or Legal Guardian: _____

Name/Relationship of Person Submitting Application: _____

Address of Person Submitting Application: _____

Phone Number of Person Submitting Application: _____

Email Address of Person Submitting Application: _____

Please answer all questions thoroughly:

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):** _____

***** 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 and approved:

Agency:	Amount applied for:	Amount approved:

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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 any services this 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			
Self-Directed Services (Broker is Contact)			
Free standing Out of Home Respite			
School			

Day Program			
Afterschool Program			
Personal Care Aide or Consumer Directed Services			

5. Please describe the individual's developmental disability in terms of the care and supervision they require:

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)?

7. Please describe the individual's area of high need (Behavioral/Medical/Both), and how it affects the person's ability to function within the family and in his/her daily environment:

8. On a scale of 1-5 (with 5 being the highest), please select the family's current stress level.

☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5**

Please explain:

9. Is this a single parent family? ○ **Yes** ○ **No**

***If yes, is the other parent involved in the care of the individual?** ○ **Yes** ○ **No**

10. Is there a provider designated to provide this service? ○ **Yes** ○ **No**

11. If approved, how will the funds be used? (Please select the letter(s) of all choices that apply)

☐ **A. <u>Increasing utilization of existing OPWDD Waiver Respite funds by supplementing the current pay rate</u>**

☐ **B. <u>Providing an additional Respite staff person (2:1 staffing)</u>**

☐ **C. <u>Employing an FSS Respite provider at an increased rate</u>**

☐ **D. <u>Phone consultation with a Behaviorist</u>**

☐ **E. <u>The family may employ a Nurse</u>**

12. Please indicate yearly income of family and number of people living in the home. *Please only list wages from employment.

$ _____

☐ **Number of people living in the home**

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** ◯ **Not Applicable (N/A)**

15. Has the Self-Direction Plan launched?

◯ **Yes** ◯ **No** ◯ **Not Applicable (N/A)**

***If yes, please attach a copy to 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 scheduled meeting regarding the results of your application.

If the applicant is approved for funds to hire a nurse or consultation with a behaviorist, a list of nursing agencies and behaviorists will be supplied to the family. However, they may hire anyone they wish to provide this service.

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

Special Needs Respite

Family Support Services - Catholic Charities Disabilities Services
1 Park Place Suite 100 Albany NY 12205, (518) 783-1111

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 who lives at home with high behavioral and/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, and receive reimbursement funds. 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 OPWDD Waiver Respite funds by supplementing the current pay rate: For example, if the person currently has approved Respite hours through the OPWDD 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 an hourly rate determined by the family, to have 2 staff to work with one individual. 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 individual 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.

C. Please submit the following information along with the completed application:

1. OPWDD Letter of Eligibility (if Provisional Eligibility letter is submitted it must be current). If the letter is not submitted the application cannot be processed.

**2. Documentation or Diagnosis indicating area of high medical and/or behavioral need: Documentation may include, but is not limited to a behavior plan, IEP, nursing notes/plan, Doctor note, physical form, psychological evaluation. ****Please highlight information which may be particularly helpful for the committee to review in relation to your request.*

3. <u>Current Life Plan -</u> * *Please highlight information which may be particularly helpful for the committee to review in relation to your request.*

4. <u>Completed "Acknowledgement and Consent" Form giving permission for CCS Staff to contact other agencies regarding this request,</u>

5. <u>Self-Diretion Budget (if plan has launched)</u>

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D. Send the completed application packet (Application, OPWDD Letter of Eligibility, Documentation of Diagnosis indicating Medical and/or Behavioral Need, ISP, and Acknowledgement and Consent Forms) to:

Catholic Charities Disabilities Services
Attention: Beth Cassidy
FSS- Special Needs Respite
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'
SNR PROGRAM

2021 MEETING SCHEDULE

February 18, 2021
****Applications due by February 4, 2021**

May 27, 2021
****Applications due by May 6, 2021**

August 26, 2021
****Applications due by August 12, 2021**

November 4, 2021
****Applications due by October 21, 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