2026 Family Support Services (FSS) Grant for Goods & Services or Respite Revised 12/16/25

Catholic Charities Disabilities Services
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 of the Diocese of Albany*** through ***Catholic Charities Disabilities Services***. The program will provide supports in ***Albany, Rensselaer, Schenectady, Schoharie, Saratoga, Fulton, Montgomery, Warren and Washington counties.***

This grant provides financial assistance to families who have limited resources and are in need of respite services or funding for certain goods 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, i.e. Insurance, Public Assistance, HEAP, etc., and that the Care Manager **has** exhausted those possibilities. Please note that any good/service requested must be related to the individual's intellectual or developmental disability and that the need cannot be based on financial basis alone. Also, FSS funds cannot be used to supplement an individual's services funded through the HCBS Waiver.

FSS Reimbursement Guidelines

Families who submit applications for respite 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 CCDS via a Respite Verification Form provided. At that point, the family is reimbursed for costs incurred. *Please note that justification is required for any hourly payments that are less than minimum wage and respite funds cannot be used for ongoing child care during parents' work hours.

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 CCDS for reimbursement. If there are circumstances preventing the family from doing this, other arrangements can possibly be made. We encourage families to consider options such as on-line purchasing and direct payments if needed. Please note that we are unable to disburse cash payments or gift cards in advance.

The DDRO only allows families to enroll with one agency for reimbursement funds, whether it is for Respite, a Good/Service, or both. This is called Single Provider Enrollment. Care Managers should ensure that an individual applying for FSS reimbursement funds with CCDS is not enrolled with another FSS agency for reimbursement.

Due to Single Provider Enrollment, the dollar amount that can be requested has been increased. Under CCDS' Goods and Services grant, reimbursement can be made for up to $3000 per individual per calendar year. Please remember that these are the amounts that can be requested but there is never a guaranteed approval amount.

Please note that we are unable to consider applications for camps outside of NYS. Any request for reimbursement toward camp expenses requires that the application include a DOH permit from the camp, unless the camp is operated or certified by OPWDD.

To be considered for reimbursement, please submit a completed OPWDD FSS Family Reimbursement Application, along with ALL of the required information 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. Individuals living independently or living in certified residential settings are not eligible for this program.

Please see the attached meeting schedule and application deadline information.

1) Do you have a denial for the item from Medicaid/Insurance (if applicable)?
☐ Yes ☐ No

If yes, please attach. If no, please explain why?

2) Please submit three estimates for the item requested, if applicable.

3) If applying for camp reimbursement, please submit a DOH Permit.

4) What is the yearly income of the family (wages from employment)?

5) Does the individual/family receive any other financial supports, i.e. SSI, SNAP, Child Support, Housing Subsidy, HEAP, etc.? Please include monthly amounts for each support.

Financial Support _____ Monthly Amount _____

Financial Support _____ Monthly Amount _____

Financial Support _____ Monthly Amount _____

Financial Support _____ Monthly Amount _____

6) Is the individual of Hispanic Descent? * This grant evolved from an agency whose ambition was to assist individuals of Hispanic origin.

☐ Yes ☐ No

7) Is this a single parent household and/or does the individual live with a grandparent?

- ☐ Single Parent Household
- ☐ Lives with a Grandparent
- ☐ N/A | 2 Parent Household

8) Is there more than one person with a disability in the home? If yes, please explain.

9) If applying for Respite reimbursement funds.

a) Does the family have a respite provider in mind, should FSS funds be approved?

☐ Yes ☐ No

b) Has the family already paid out of pocket for respite in 2026? If yes, what is the amount already paid?

☐ Yes ☐ No

Amount:

10) Cost Effective Options Explored- What other cost-effective items were explored and why were more cost-effective alternatives not chosen if they were available?

11) Provide Weblink to Item- Please provide a weblink to the item, if applicable:.

12) Alternative Funding Sources Explored- What alternative funding sources were explored i.e.,Waiver Services or Self-Direction, other community resources, etc. and what was the outcome?

13) Is the individual enrolled in the HCBS waiver?

Please send the completed application to:

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

Applications can also be sent via secure email to bethc@ccdservices.org or faxed to 518-785-4894.

For questions, please contact Beth at 518-783-1111, x1287

OPWDD FSS FAMILY REIMBURSEMENT APPLICATION

Application must be filled out completely in order to be considered

1. NAME OF INDIVIDUAL RECEIVING SERVICES:	
1a DATE OF BIRTH:	1b. TABS NO.:
1c. ADDRESS (Street/Town/Zip):	
1d. COUNTY:	1e. NUMBER OF PEOPLE IN THE HOME:
2. NAME OF PARENT / RELATIVE / GUARDIAN:	
2a. PARENT / GUARDIAN EMAIL:	2b. PARENT / GUARDIAN PHONE #:
3. CARE MANAGER'S NAME:	3a. CARE MANAGER'S ADDRESS (Street/City/Zip):
3b. CARE MANAGER'S EMAIL:	3c. CARE MANAGER'S PHONE #:
4. FISCAL INTERMEDIARY (If Applicable- Name/Agency/Phone/Email):	

5. DIAGNOSIS – PLEASE CHECK ALL THAT APPLY PER OPWDD

☐ Intellectual Disability ☐ Traumatic Brain Injury – TBI ☐ Other

☐ Autism ☐ Cerebral Palsy

☐ Epilepsy (seizures) ☐ Neurological Impairment

6. WHAT IS THE ITEM (S) OR SERVICE REQUESTED FOR REIMBURSEMENT – PLEASE DESCRIBE:

Please note - camp can only be reimbursed if the camp has a permit by the New York State Department of Health and/or Local Department of Health pursuant to Subpart 7 of the New York State Sanitary Code (see 10 NYCRR Subpart 7).

TOTAL AMOUNT REQUESTED ON THIS APPLICATION:

* IS THIS ITEM/SERVICE AN IMMEDIATE CRISIS SITUATION AS IDENTIFIED IN THE GUIDELINES? Please check one:

YES ☐ NO ☐

7. HAVE YOU TRIED FOR FUNDING FROM PRIMARY MEDICAL INSURANCE, INCLUDING FLEXIBLE SPENDING ACCOUNT OR OTHER SOURCES SUCH AS MEDICAID, MEDICARE, SELF DIRECTION, HCBS WAIVER – ENVIRONMENTAL MODIFICATIONS OR ASSISTIVE TECHNOLOGY, ETC.

YES ☐ NO ☐ **RESULTS**

7a. IS THE INDIVIDUAL ENROLLED IN MEDICAID? YES ☐ NO ☐

7b. WHAT SERVICES ARE YOU RECEIVING EITHER THROUGH THE HOME AND COMMUNITY BASED (HCBS) WAIVER AND/OR OPWDD STATE PLAN SERVICES?

☐ RESPITE ☐ DAY HABILITATION ☐ LIVE-IN CAREGIVER ☐ PREVOCATIONAL SERVICES

☐ RESIDENTIAL HABILITATION ☐ SUPPORTED EMPLOYMENT ☐ COMMUNITY TRANSITION SERVICES

☐ FISCAL INTERMEDIARY ☐ INDIVIDUAL DIRECTED GOODS AND SERVICES ☐ SUPPORT BROKERAGE

☐ ASSISTIVE TECHNOLOGY – ADAPTIVE DEVICES ☐ COMMUNITY HABILITATION ☐ ENVIRONMENTAL MODIFICATIONS

☐ FAMILY EDUCATION & TRAINING ☐ INTENSIVE BEHAVIORAL SERVICES ☐ PATHWAY TO EMPLOYMENT

☐ VEHICLE MODIFICATIONS ☐CARE COORDINATION SERVICES ☐ CRISIS SERVICES FOR INDIVIDUALS WITH INTELLECTUAL/DEVELOPMENTAL DISABILITIES

☐ ARTICLE 16 CLINIC

7c. IS ANYONE RESIDING IN YOUR HOME RECEIVING PAYMENT TO PROVIDE CARE TO THE INDIVIDUAL RECEIVING SERVICES?

YES ☐ NO ☐

8. LIST ALL REIMBURSEMENT APPLIED FOR AND/OR RECEIVED THIS CONTRACT YEAR: (add a page if needed): This information **MUST** be reported. Please be advised that $3,000 is the maximum total amount that may be reimbursed. If you have a large reimbursement request that exceeds an agency internal cap and you are submitting to multiple agencies for partial reimbursement, you must indicate this in the spaces below.

AGENCY	DATE	AMOUNT	APPROVED	DENIED	PENDING
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐

9. CHECKLIST OF REQUIRED DOCUMENTS: (Please attach to this application)

☐ **Signed application, receipts/invoice (photocopies and digital copies are acceptable), respite verification forms. (If receipt has been submitted to another agency for partial reimbursement, list what agency has the receipt.)**

☐ **Clinical justification / letter from physician or clinician if the request is for a clinical item / service**

☐ **If enrolled in Self-Direction, a copy of the most recent self-direction expense report or budget which verifies that Family Reimbursement is accounted for.**

☐ **If enrolled with a CCO, a copy of the most recent life plan with FSS family reimbursement properly documented.**

10. HOW DOES THIS REQUEST DIRECTLY RELATE TO THE INDIVIDUAL'S DISABILITY? Please add a page or reply in the area below. Be specific and provide justification as appropriate.

In the event that a claim for goods or services is discovered to be fraudulent, the agency to which that reimbursement application was submitted is to be notified (if not the discovering entity) and will investigate the request in question and all documentation provided with the reimbursement request. In the event that the fraudulent claim is confirmed, the individual/family will be required to pay the amount reimbursed back to the agency (if the service/good was already reimbursed) and will be suspended from any future reimbursement for goods and services for a period of time determined by the agency and OPWDD. The recipient of the reimbursement may also be subject to legal actions as determined by the agency and OPWDD.

Families may submit requests for Reimbursement to the RO or a FSS Reimbursement provider agency at any time, depending upon which entity administers the reimbursement program in that region, using the form provided by the Family Reimbursement provider agency or obtained from the individual's Care Manager or Care Coordinator. Funds are available only on a contract year basis. Any authorized, but unused, reimbursements may not be carried over by a receiving family from one year to the next. For self-directing individuals, verification is made to ensure that the FSS program is included in the current budget. Inclusion of funding in the budget does not guarantee that the request will be approved. Reimbursement requests must be consistent with FSS guidelines. Applications may be submitted to any of the Family Reimbursement Program providers by individuals, families, case managers or advocates. Anything submitted more than 90 days after purchase/occurrence will be awarded per the discretion of the Reimbursement Program provider. Applications that are not filled out in full will be returned, and payment will be delayed.

***I HAVE READ THE STATEMENT ABOVE AND UNDERSTAND THAT INFORMATION RELATED TO MY REQUEST FOR REIMBURSEMENT MAY BE MUTUALLY SHARED WITH AND/OR RECEIVED FROM OTHER AGENCIES WITHIN THE OPWDD REGION/DISTRICT:**

11. Print Name of Parent/Guardian signing form:	11a. Date Completed:
11b. **Parent/Guardian Signature**: _____ * SIGNED APPLICATION MUST BE SUBMITTED	
12. If Submitted By Care Coordinator, Print Name:	12a. Name of Care Coordination Organization (CCO):
13. Date Submitted:	

CATHOLIC CHARITIES DISABILITIES SERVICES'
GOODS/SERVICES PROGRAM
2026 Meeting Schedule

February 2, 2026
Applications due by January 19, 2026

April 6, 2026
Applications due by March 23, 2026

June 8, 2026
Applications due by May 25, 2026

July 20, 2026
Applications due by July 6, 2026

September 21, 2026
Applications due by September 7, 2026

November 23, 2026
Applications due by November 9, 2026