Catholic Charities Disabilities Services
2026 Family Support Services (FSS) Grant for Special Needs Respite
(Revised 12/16/25)

1 Park Place, Suite 100 Albany, NY 12205
(518) 783-1111

Instructions: Please read thoroughly prior to completing application.

A. Description of Grant:

Catholic Charities Disabilities Services' Family Support Services Special Needs Respite Grant provides financial assistance to families who are in need of Respite Services, are caring for a family member with high behavioral and/or medical needs, and have limited resources. Families are eligible to apply if they have a family member who lives at home and the family member has OPWDD Eligibility approval. Eligible applicants must also live in one of the following counties: Albany, Rensselaer, Schenectady, Schoharie, Saratoga, Fulton, Montgomery, Warren and Washington counties.

Please note that respite funds cannot be used for ongoing child care during parents' work hours. Also, funds cannot be used to supplement an individual's services funded through the HCBS Waiver or Self-Direction.

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 per individual, per calendar year has been increased. Requests for Special Needs Respite Reimbursement can be made for up to $3000 per individual per calendar year. Please remember that this is the amount that can be requested but there is never a guaranteed approval amount.

Families who submit applications for this service and who have been notified that they are approved for Special Needs Respite Reimbursement are responsible for hiring their own provider and scheduling with that provider. Documentation that the Respite hours were provided is submitted to CCDS, via a Respite Verification Form provided. At this point, the family is reimbursed for costs incurred. *Please note that justification is required for any hourly payments that are less than minimum wage.

B. Respite funds can be used in any of the following ways:

Providing an additional Respite staff person (2:1 staffing):
Families have a choice of hiring an additional Respite provider to have 2 staff to work with one individual. This may be needed when a person has high behavioral needs and wants to go out into the community. Or, for someone with high medical needs, the individual could safely go out into the community, especially if they need a two person transfer.

Employing an FSS Respite provider at an increased rate:
This choice would enable the family of an individual with a great deal of behaviors or medical needs to pay a higher rate to a provider for Respite (up to $23/hour).

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 is able to privately hire a nurse with the money approved through this grant and be reimbursed for up to $23/hour.

**Please note for all options that the reimbursement rate cannot exceed the DOH reimbursable rate.*

C. To be considered for reimbursement, please answer the following questions and submit, along with the completed application. Please note that all questions must be answered completely to have the application considered for approval.
The individual must be a resident of one of the counties listed above and live at home with his/her family. Individuals living independently or living in a certified residential setting are not eligible for this program.

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

_____

2) 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 _____

3) Is the individual enrolled in the HCBS waiver?

☐ Yes ☐ No

4) 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

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

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

☐ Yes ☐ No

7) On a scale of 1-5 (with 5 being the highest), what is the family's current stress level? Please provide details.

8) Has the family already paid out of pocket for respite in 2026? If yes, what is the amount paid? _____ ☐ Yes ☐ No

**Please also submit Documentation indicating the area of high medical and/or behavioral need: Documentation may include, but is not limited to a behavior support plan, IEP, nursing notes/plan, Doctor's note, physical form, or psychological evaluation.

Please send the completed application to:

Family Support Services– 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 – Attention: Beth Cassidy

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'
SNR PROGRAM
2026 Meeting Schedule

February 25, 2026
Applications due by February 11, 2026

May 20, 2026
Applications due by May 6, 2026

August 26, 2026
Applications due by August 12, 2026

October 28, 2026
Applications due by October 14, 2026