Community, Work and Independence
PO Box 303
Glens Falls, NY 12801
(518) 792-7548 ext 122

Family Support Services (FSS) Family Reimbursement Grant Application

CWI's **Family Empowerment** program provides financial assistance to families with a member having a developmental disability. CWI provides FSS grants to families who reside with a family member diagnosed with a developmental disability residing in Warren, Washington and Northern Saratoga Counties. The committee facilitator brings together a committee comprised of professionals and family members who are often previous recipients of the funding. Families may receive reimbursement for transportation, specialized training, adaptive equipment, environmental modifications, supplies, medical supplies and respite services.

Grants are distributed to approved applicants on an annual basis. Applications should be turned into our office by the beginning of January. Requests are reviewed on an anonymous basis. Decisions are based on the following: Waiver, Medicaid or private insurance funding denial, the need for the item or service, previous grants received by the family, and how the grant will improve the individual's quality of life.

Anyone wishing to submit a request must include the following:

- A completed grant application
- A detailed justification for the request
- A completed DDP1
- If you are requesting a service or item the agency requires a statement from the vendor stating the cost of the item/service, and mailing address. If you have already purchased the item, please include the receipt with your application. **(We can not pay for items purchased prior to the current approval year.)**

After the grant committee has met the agency will contact you via mail as to the decision of the committee. Letters of approval or denial will be generated within one month of the meeting date. Unfortunately we are not always able to approve all requests. All receipts for items/goods must be submitted to the agency by September 15th of the grant year. Subsequent grants will not be considered if receipts have not been submitted. Respite Reimbursement Logs must be turned in on a monthly basis. At least half of the respite funds must be used by September 15th. The committee takes into consideration any special request regarding the deadline as long as the recipient contacts the program director to review the circumstances on an individual basis.

Thank you for applying to our agency for a FSS grant. Please contact April Boucher at (518) 792-7548 ext 122 or aboucher@cwinc.org with any questions or assistance needed in completing the application.

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FSS Grant Application Check List

(PLEASE RETURN WITH COMPLETED APPLICATION)

____ CONSUMER /MSC INFORMATION COMPLETE (MEDICAID, TABS, PHONE #'s, ADDRESS

_______SIGNATURE OF CONSUMER OR PARENT/GUARDIAN (REQUIRED TO PROCESS)

_______DDSO ELIGIBILITY DOCUMENTATION

_______DDP1 (LEAVE SECTION 7, 8, 9 & 10 BLANK)

_____ JUSTIFICATION FOR REQUEST (including clinical reports if applicable.)

_______PAID DOCUMENTATION OF REIMBURSEMENT REQUEST FOR SERVICES or items ALREADY PROVIDED during 2011 (receipts must be dated in current approval year.)

_______(3) ESTIMATES (IF APPLICABLE) INCLUDING VENDOR NAME & MAILING ADDRESS

_______DENIAL LETTER FROM MEDICAID, PRIVATE INSURANCE OR WAIVER SERVICE (ENVIORNMENTAL MODIFICATION OF ADAPTIVE TECHNOLOGY REQUIRED (IF APPLICABLE)

_______NAME & PHONE NUMBER OF PROVIDER IF REQUESTING A SERVICE SUCH AS RESPITE REIMBURSEMENT, PIANO LESSONS, MUSIC THERAPY, TUTORING, ETC

- **Application needs to be legible and completed in full to be submitted for review. Submitting applicants will be notified of incomplete applications at the convenience of the program director.**

____ _______________

Signature of person completing application Date

____ _______________

Agency Phone/ext

E mail address: ____

Office Use Only:

Category: Last Name: Date of Application:

Completed By: Date Received:

Community Work and Independence
PO Box 202
Glens Falls, NY 12801

APPLICATION FOR FAMILY REIMBURSEMENT GRANT 2011

Name of Applicant (Person with Disability):______________________________

Street Address: ____

City: ___________________________State:__________ Zip Code: _________

DOB: _______________ Male/Female (circle one) SSN: ________________

Medicaid #:_________________________ TABS ID: __________________

Persons living in the Home (only parent(s)/guardian(s) and children under 18):

Parent/Guardian (First/Last) _____________________________________

Home phone #_______________________ Work/Cell: _______________

Parent/Guardian (First/Last) _____________________________________

Home phone #_______________________ Work/Cell: _______________

Children under *18 (do not include applicant):*

Name: ________________________Relationship: ___________Age: _____

Name: ________________________Relationship: ___________Age: _____

Name: ________________________Relationship: ___________Age: _____

Name: ________________________Relationship: ___________Age: _____

Name: ________________________Relationship: ___________Age: _____

Name: ________________________Relationship: ___________Age: _____

Medicaid Service Coordinator Information (completed by MSC):

Is the applicant enrolled in Medicaid Waiver? Yes/No or Pending (circle one)

Service Coordinator's Name: ____

Agency Name________________________________ Phone#:________________

Street Address: ____

City: ___________________________State:____________ Zip Code: ___________

Email Address: ____

Please list any other Waiver and/or Respite Services the applicant receives:

Service	Agency Name	Agency Phone #

Disability Information:

Please check those that apply:

Mental Retardation_____ Cerebral Palsy____ Epilepsy____ Autism_____ TBI_____
Down Syndrome_____ Visually Impaired_____ Hearing Impaired_____
Spina Bifida_____ Other____

Any other medical concerns:

____

____

____

Please indicate any major shift in the family dynamic within the past year that has caused undue hardship (i.e. Loss of a job, hospitalization, death etc.)

____

____

____

____

____

Other Grant Information:

Please list all grants that the applicant has received since the beginning of the current calendar year:

Item(s) Received	Agency Name	Cost of Item	Date Received
Item(s) Received	Agency Name	Cost of Item	Date Received
Item(s) Received	Agency Name	Cost of Item	Date Received
Item(s) Received	Agency Name	Cost of Item	Date Received

Is the applicant currently applying elsewhere with this same request: Yes / No

____
AGENCY NAME PHONE # DATE REQUESTED

Has the applicant been denied for this request this calendar year: Yes/ No

____
AGENCY NAME PHONE # DATE REQUESTED

____
Reason for Denial

What expenses to you have related to your family member's disability?

____

What health insurance do you/your family currently have?

____

Current Request:

- **A minimum of three estimates is required for applicable items (adaptive equipment) * A denial letter form Medicaid, private insurance or Waiver Service is also required for applicable items (adaptive equipment, environmental modifications, and medical request/services. *A note from Dr's/clinicians supporting the service denied by Medicaid/private insurance (Speech, OT etc.)**

Specify the service/time you are requesting by check below:

_____ Respite **______Personal Care Aid** **_____Personal Care Supplies**

_____Tuition or fees to a program **_____Tutor** **_____Adaptive Equip**

_____Environmental Modifications

_____Other (specify) ____

Amount Requested$______________________ **Price of item: $___________________**

Are you able to contribute any amount towards the item/how much:

____

____

Please describe in detail how this service/item would enhance you or your family's life (include additional pages if needed):

____

____

____

____

____

____

____

____

____

Please complete this section only if you are requesting respite reimbursement: All information is mandatory:

1. **Does the applicant currently receive waiver respite or any other respite?**
   Yes/No ____
   Agency Name **Form of Respite** **hours/week**

2. **Does the applicant currently receive Residential Habilitation?**
   Yes/No ____
   Agency Name **Form of Respite** **hours/week**

3. **If the applicant is already receiving one of these services, please explain why it is necessary to receive additional services:**

____
____
____
____
____
____
____
____
____
____

Signature (Required):

____
Applicant **Print Name** **Date**

____
Parent/Guardian **Print Name** **Date**

____
Medicaid Service Coordinator **Print Name** **Date**

Thank you for your application, if you are approved-you will receive written notification in the mail.