Warren, Washington and Albany Counties' Chapter of The ARC NY.
2019 Goods and Services Reimbursement Application
436 Quaker Rd. Queensbury, NY 12804
(518) 793-4204

Instructions: *(Please read thoroughly prior to completing application)*
The Warren, Washington and Albany Counties' Chapter of The ARC NY. (WWAARC) provides Reimbursement of Goods and Services in ***Warren, Washington and Albany Counties.***

This is a New York State funded grant program that is contracted through OPWDD. This grant provides financial assistance to families who are in need of reimbursement for certain goods/services that are necessary *to directly support the individual with the developmental disability*. These goods/services must be related to a need or goal identified in the person's Life Plan, be for the purposes of increasing independence, promote opportunities for community living and inclusion, be able to be accommodated without compromising the participants health or safety and be provided to or directed exclusively toward the participant. The individual must be a resident of one the counties listed above. 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 (public assistance, heap, etc), and that the Care Manager has exhausted those possibilities first.

Reimbursement Guidelines:
To be considered for reimbursement, you must **submit a completed application with ALL of the required documentation listed below.** (Please note that all questions must be answered completely to have the application considered for approval).
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 reimbursement coordinator listed below to discuss these circumstances. Consideration will be given to individuals who have not previously accessed funds from this grant.

You will be notified by mail or email if your request is approved. Once receipts for the goods and/or services purchased are received, WWAARC will provide reimbursement to the family for costs incurred up to the committee allocated dollar amount. Families are responsible for obtaining their own goods and/or services. In *special circumstances* (when approved by the allocation committee) vendors *may* be paid directly.

The following must be included with this application to be considered:

_____ OPWDD Letter of Eligibility

_____ Most Recent Life Plan (or IEP if applicable)

_____ Three estimates (if applicable – Furniture, adaptive equipment, appliances etc.)

_____ A denial letter from Medicaid, private insurance or Waiver Service is required for applicable items (adaptive equipment and medical request/services etc).

_____ Psychological Evaluation if it supports the request.

Please return completed applications to:
Nichele Beyer, Assistant Director of Family Support Services
Warren, Washington and Albany Counties' Chapter of The ARC NY.
Goods and Services Reimbursement Program
436 Quaker Rd. Queensbury, NY 12804
Phone: (518) 935-4335
Fax: (518) 615-2194
Email: nichele.beyer@caparcny.org

WWAARC Reimbursement Grant Application
Goods and Services

Individual Information

Name of Individual: _____ Date of Application: _____

Date of Birth: _____ TABS ID: _____

Medicaid Number: _____ County_____

Parent(s) and/or Legal Guardian(s): _____

Address: _____

_____

Phone Number: _____

Background Information

What is the Individual's Diagnosis? (Please Specify and describe the disability - doctor reports may be submitted to help describe the disability if necessary):

_____

_____

_____

Please describe the individual's abilities in terms of the care and supervision they require from others (please be as descriptive as possible):

_____

_____

_____

_____

_____

CCO Information (completed by CM):

Is the applicant enrolled in Medicaid Waiver? **Yes / No** or **Pending** **(Please Circle One)**

Care Manager's Name: _____

Agency:_____ Phone:_____

Email Address: _____

Is the individual enrolled in Self Direction? **Yes / No** **(Please Circle One)**

Broker Contact Info:_____

Request for Good(s) or Service(s)

1. Requested item/service:

_____

_____

2. Cost of item: $_____

3. Are you able to contribute any amount towards the item? **Yes / No (Please Circle One)**

If Yes, how much $_____

4. **Total Amount requested** $_____

5. Please explain the need for these goods/services and this reimbursement. How are funds to be used? How will they improve/enhance the individual's life? (This question must be answered thoughtfully and thoroughly.)

_____

_____

_____

_____

6. Is this family in crisis? **Yes / No (Please Circle One)**
If yes, please explain the nature of the crisis:

_____

_____

_____

7. Are there any unique circumstances about the family situation that you would like to share with us that further supports the need for this request? (ex. Is this a single parent family? Is there anyone else in the home with a disability? etc.)

8. Has the individual applied for/been approved for FSS funds for this through *any* agency this year?

Yes / No (Please Circle One)

If yes, Please list all agencies and reasons and indicate amount applied for or approved:

Agency	Reason	Amount Applied for	Amount approved

9. Has the individual applied for funds through THIS GRANT previously? If so, list dates applied and if funding was approved through this grant.

Date(s) Applied:	Funds Granted?	
	Y	N
	Y	N
	Y	N
	Y	N

10. Please indicate all services the individual is receiving at this time (must be filled out completely).

Type of Service	**Agency Providing Service**	**Contact Person and Phone Number**	**How often is this service currently being provided?**
Early Intervention			
Care Management			
Community Habilitation			
In Home Respite			
Free Standing Respite			
School/ Day Program			
Self-Direction			
Other Funding Sources			

11. Please indicate the annual income of the family and the number of people living in the home. (This question must be completed):

Annual Income: $_____/per year

Number of people living in the home _____ How many Adults? _____ Children? _____

Please describe the family's housing: **Renting / Own Home / Lives with family or friends.**

Thank you for taking the time to complete this application.

Please understand that our committee receives many applications from families who are in need of Reimbursement for Goods and Services. Approval is not guaranteed. We review each application very carefully and approve funds for as many families as we can within our limited budget. You should expect to hear from us soon after our next meeting regarding the results of your application.

***Please note that incomplete applications will not be reviewed by the committee and will hold up the approval process for the individual in need. Please fill the application out in its entirety.**

Committee Meeting Schedule

December for the 1st Quarter

March for the 2nd Quarter

June for the 3rd Quarter

September for the 4th Quarter

Name of Person Submitting Application: _____

Complete Address : _____

Phone Number of Person Submitting Application: _____

Email Address of Person Submitting Application: _____

Relationship to the Person with Disability: _____

Signature:_____ Date: _____

Please return completed applications to:

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