Warren, Washington & Albany Counties' Chapter of The ARC, NY

Application for Respite Reimbursement

General Contact Information

Individual's Name: _____ DOB:_____

TABS ID:_____ Medicaid ID:_____

Caregiver's Name(s):_____

Street Address:_____

City, State, Zip:_____

Primary Phone Number:_____ Alt. Phone:_____

Email:_____

Care Management

Care Manager:_____ Agency:_____

Phone:_____ Email:_____

Eligibility

Nature of individual's developmental disability:

____ Autism Spectrum Disorder ____ Seizure Disorder

____ Cerebral Palsy ____ Hearing Disability

____ Intellectual Disability ____ Other (specify):_____

____ Neurological Impairment _____

Required: Please attach a copy of OPWDD Eligibility and most recent Life Plan

1. This is a *reimbursement* program. The respite service must first be rendered prior to submitting for reimbursement. After all correct, completed documentation has been submitted and approved, Reimbursement will be made out to the parent/caregiver.
2. Reimbursement is not available to reimburse for services rendered by the Parent(s) and/or direct caregiver(s) with whom the individual requiring respite services is living with.
3. The Parent/Caregiver is responsible for hiring & training their own respite worker.

Please List Below and other services that the individual is currently receiving or enrolled in:

Type of Service	Agency Providing Service	Contact Person and Phone Number	How often is this service currently being provided?
In Home Respite			
Free Standing Respite			
Community Habilitation			
Self-Direction			
Other Funding Source(s)			

Funding Request:

A. Total Number of hours requested per quarter: _____
   a. Hours per month multiplied by 3 Months.
B. Respite Worker Hourly Rate to be paid: _____
   a. We can only Reimburse up to $10/hr at this time.
C. Total Amount Expected to Pay out per quarter: $_____ (A x B)

Are there any special circumstances related to this application that you want the committee to be aware of? **Y / N** If Yes, please explain…

_____

_____

_____

I certify that the information above is complete and accurate to the best of my knowledge.

_____ _____

Signature Date

_____ _____

Printed Name Relation to Individual

Please return completed applications to:

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