



Warren, Washington & Albany Counties' Chapter of The ARC, NY
Application for Sitter 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: _____

The Sitter Reimbursement Application must include the following:

1. Completed Application
2. Current Life Plan
3. Letter of Eligibility
4. Parent/Caregiver's ID (Driver's License, Passport, etc.)
5. Self-Direction Budget (If applicable)

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:
 Family Support Services - Family Reimbursement Program
 Warren, Washington and Albany Counties' Chapter of The ARC NY.
 436 Quaker Rd. Queensbury, NY 12804
Email: family_reimbursement@caparcny.org **Fax:** (518) 615-2184