Warren, Washington and Albany Counties' Chapter of The ARC NY.
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 to people living in ***Warren, Washington and Albany Counties, ONLY.***

- 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. 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 on the last page of the application).**
- 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.
- Please understand that our committee receives many applications from families for Reimbursement of 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 see our Application timelines listed below.

Application Timelines

- Our Family Reimbursement committee meets on a quarterly basis to review new applications. Meetings are held in the 3rd week of the month prior to the new quarter therefore **to be reviewed, applications must be received by the end of the second week of the month prior to the upcoming Quarter.** Any applications received after this deadline will be added to the following quarter's agenda unless it is deemed urgent.

Quarters are defined as:
1st Quarter- January, February & March
2nd Quarter- April, May & June
3rd Quarter- July, August & September
4th Quarter- October, November & December

WWAARC's Family Reimbursement Goods and Services Application

Applicant (Person Supported)

Name: _____ Date of Birth:

_____

TABS ID: _____ Medicaid Number: _____

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

Address: _____

County: _____ Phone Number: _____

Email: _____

CCO Information

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

Care Manager's Name: _____

Agency: _____ Phone: _____

Email Address: _____

Financials

- Is the applicant enrolled in Self Direction? **Yes* / No (Please Circle One)**
  ***If yes**, Please complete the information below and send a copy along with other documentation.

Broker Name/Agency: _____ Phone Number: _____

Email: _____

FI Name/Agency:_____ Phone Number:_____

Email:_____

- Is the applicant or their family in crisis? **Yes* / No (Please Circle One)**
    - ***If yes**, please explain in the required Justification letter.
- Please indicate the annual income of the family and the number of people living in the home. (This question must be completed):
    - Annual Income: $_____/year
    - Number of people living in the home: _____
        - How many Adults?_____ Children? _____
    - Housing Status: **Renting / Own Home / Lives with family or friends.**
- Has the applicant applied for/been approved for FSS funds through *any* agency in the past year?

Yes / No (Please Circle) ***If Yes**, please list all agencies, reasons & amounts below.

Agency	Reason	Amount Requested	Amount & Date Paid Out

- Has the applicant applied for funds through WWAARC's Family Reimbursement previously?

Yes / No (Please) If yes, list dates & outcome below.

Date Applied	Amount Requested	Approved?	If Yes, List Amount & Date Paid Out
		Yes / No	
		Yes / No	
		Yes / No	

Request for Good(s) or Service(s)

- **Requested item/service:**_____

_____

_____

- **Cost of item/service**: $_____

- Are you able to contribute any amount towards the item? **Yes / No**

(Please Circle)

  - **If Yes**, how much? $_____

- **Total Amount requested** $_____

- **Justification Letter (REQUIRED):** Please compose a Justification Letter answering the following Questions.

- 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.)
- 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? Is the family in crisis? etc.)

Thank you for taking the time to complete this application.
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.).

- **A Copy of the Parent/Caregiver's Valid Driver's License or ID containing their Full Name, Address, and Date of Birth.**
- **A Justification letter explaining how and/or why this request directly impacts the person supported.**

*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.

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:
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