Family and Child Service of Schenectady, Inc.
1007 Maryland Ave.
Schenectady, NY 12308
(518) 372-2814

Family Support Services Family Reimbursement Grant

Family and Child Service of Schenectady, Inc. provides Family Support Services (FSS) grants to individuals diagnosed with a developmental disability. The terms and conditions of this grant program are consistent with the New York State Office for People with Development Disabilities (OPWDD) requirements. Eligible individuals must reside with a family member in Schenectady, Albany, Saratoga, Schoharie, or Rensselaer Counties.

Grants are available for the purpose of enhancing the health and safety of the eligible individuals. Grants may be considered for: purchasing goods and services; providing respite reimbursement; recreation reimbursement; and for emergency funding relating to the imminent threat to the health and safety of the individual.

Requests for grants are submitted to the FSS Program Director with a fully completed application which must be accompanied with all required attachments (see application checklist). The Program Director reviews each application to ensure it meets application requirements. Each calendar quarter the FSS Grant Committee reviews grant requests and make the determination to either approve or deny those grant requests. This voluntary committee is made up of family members of individuals with developmental disabilities. Each grant reviewed by the committee will not contain any identifying personal information during the actual review, so that decisions remain objective and unbiased.

A W-9 tax form is required and must be completed when a recipients Grant Awards for the calendar year reaches $600.00 or more regardless of the number of grants and the types of grants.
Following the fourth quarter Grant meeting of each calendar year the Program Director will: identify those grant applicants that have exceeded the $600.00 limit; send a required W-9 form with further instruction; the W-9 form must be completed by the applicant family and/or caregiver; the W-9 form must be returned within two (2) weeks.

Grant decisions generally include the following considerations:

- Requests that are eligible for funding through other sources such as Medicaid Waiver Services (e.g. E mods, adaptive technology, therapy, etc), may be considered for FSS grant money only if they have been denied funding through those sources. These requests require a denial letter from the funding source before submission for review.
- Assurance that other appropriate resources such as private insurance, County Departments of Social Services and other funds are not available.
- Requests that do not solely benefit the identified individual may be subject to partial funding approval (e.g. washer, dryer, couch, etc.).
- Requests that identity a possible risk and liability to the consumer may not be approved (e.g. pools, trampolines, etc.).
- Justification must indicate how the grant will improve the individual's quality of life in relation to their health and safety **and why the family cannot purchase the item through their own resources**.

- **Emergency Funding-** Requests for emergency funding are reviewed at the time they are received. Emergency funding determinations are made promptly. Decisions for emergency funding are based on the same criteria as listed previously. Emergency grants are limited to one time each calendar year. Each request for emergency funding will require an action plan to avoid further emergency situations.

Family Support Services Grant/Reimbursement Program Guidelines
For
Family and Child Service of Schenectady

The FSS Grant Committee will meet and make a determination about each grant request. Once a determination has been made, the Agency FSS Program Director will contact the applicant via mail to indicate the determination of the committee.

Letters for approval or non-approval for **emergency requests** will be generated within two weeks from the date of determination. Letters of approval or non approval for **non- emergency requests** will be generated within one month of the Committee's determination.

Here are the primary considerations and conditions for Grant requests:

Respite

- The total dollar amount of FSS respite reimbursement grant funding approved per consumer, per calendar year is $900.00 (as funds are available).
    - The award amount for respite reimbursement will not exceed (be limited to no higher than) $300.00 increments.
    - A second and/or third request for an additional $300.00 will only be considered: as funds are available; and after all previous respite reimbursement vouchers have been submitted for payment and have been approved by the Director of FSS.

- Respite reimbursement will only be considered in the 1st, 2nd, and 3rd quarter of the year.
    - A new grant application will need to be submitted for each request.
    - Priority will be given to consumers who are not approved to receive waiver respite and/or community habilitation services.
    - The Agency will only reimburse up to $15.00 per hour of respite service.
    - FCSS Liability Indemnification and Disclosure Agreement must be completed for each calendar year prior to reimbursement.

Goods and Services

- Requests for services such as, but not limited to, music therapy, therapeutic horseback riding, sign language, piano l e s s o n s , etc. will be awarded one (1) time per calendar year. These will only be considered in the 1st, 2nd, and 3rd quarter of the year. The award amount may be up to 12 sessions but not to exceed a total reimbursement of $750 per calendar year.

- Requests for therapeutic/technological services must have a physician prescription or therapist justification and a documented denial from Medicaid or any other insurance that the service will not be covered.

- Requests for clothing or other related items must be related to the consumer's disability. (E.g. ripping, tearing, and soiling of clothing.etc.)
    - Eligible applicants may apply for this two (2) times per calendar year.
    - The award amount per request will be limited to no higher than $250.00 increments (as funds are available).
    - The maximum amount that could be awarded per calendar year will not exceed $500.00.

- Requests for food must be related to the consumer's disability. (Special diet, gluten free or foods otherwise not covered by Medicaid).
    - Eligible applicants may apply for this request two (2) times per calendar year.
    - The award amount per request will be limited to no higher than $250.00 increments (as funds are available).
    - The maximum amount that could be awarded per calendar year will not exceed $500.00.

Recreation

- Grant requests for recreation funding will be awarded one time per calendar year.
- The award amount will not exceed $250.

Request for Emergency funds:

- Eligible individuals must demonstrate an urgent need (imminent eviction or cancellation of utilities: electric and/or heating source) that presents a significant threat to the health and safety of an individual with a developmental disability.

- Requests must:

    - Verify impending eviction or termination of services from the appropriate vendor.
    - Provide current utility statement.
    - Verify that all other payment options have been exhausted (i.e. HEAP, budget plans, DSS, etc.)

- Rental assistance is limited to one (1) month of rent. The name, address and phone number of the property owner must be included with the request.

- Security payments will not be funded.

- Families of low income will be given priority.

- Individuals will only be eligible to receive emergency funding one (1) time per calendar year, with the maximum amount determined by the grant committee.
    - Emergency grant requests can be submitted at any time throughout the year.
    - They will be reviewed by the committee as they are received and a determination will be made approximately within a two week period.
    - Notification of the approval or non-approval will be made to the individual and the MSC.
    - The committee will require an action plan to avoid future emergencies.

- Emergency grant requests are to be submitted on the FCSS Family Reimbursement Grant Application. The request needs to be identified under **EMERGENCY REQUEST** which is located on page 3 of the application.

General Information

- If requesting reimbursement of an item already purchased:
    - an original paid receipt must accompany the grant request within the calendar year of the request; and
    - the request cannot exceed the cost of the good or service.

- Individuals whose waiver eligibility (provisional) has lapsed will be considered for grant awards if justification is submitted that their eligibility is in the process of being re-determined.

- Individuals must live as part of a natural family unit in their own family home to be eligible for grants. Families of one person are not eligible.

- Grant applications must be completely filled out and legible.

- All information requested (as applicable) on the FSS Grant Application Check List must be included.

- If a gift card, Purchase Order or vendor check is the approved funding source for the grant, FCSS requires that the MSC assist or accompanies the family when the approved purchase is made.

- Receipts of any items purchased through this FSS grant funding source must be submitted to the Director of FSS no later than one (1) month after the letter has been received. Subsequent grants may not be considered if receipts have not been submitted.

- Purchase orders or gift cards are only good for 6 weeks from the date of issue.

- **Goods and services not allowable for reimbursement::**
  - Taxes, penalties, and fines;
  - Goods and services covered through other funding mechanisms such as Medicaid, private insurance and County Department of Social Services; and
  - Any goods or services not related to the care of the family member with a developmental disability.

Income

- All grants awarded will be prioritized by:
  - the ability to enhance the health and safety of the individual;
  - income level;
  - number of family members, and
  - the justification for services.
- The amount of the award will consider the family's income and family size. The attached sliding scale will determine the family contribution, if any.

Sliding Scale

The amount of the family's contribution is based on the following scale:

SLIDING SCALE

GROSS TAXABLE INCOME DOLLAR AMOUNT	FAMILY CONTRIBUTION %OF THE FULL AMOUNT
1-34,999	0%
35,000-64,999	25%
65,000-84,999	50%
85,000-99,999	75%
100,000 and above	100%

Thank you for applying to our agency for a FSS grant. Please contact Toni Wakefield at (518) 372-2814 or twakefield@familyandchildservice.com with any questions or assistance needed in completing the application.

Office Use Only:
Category: _____ Name: _____

FSS REIMBURSEMENT GRANT APPLICATION
1007 Maryland Ave. Schenectady, NY 12308
(518) 372-2814 Fax: 518- 374-3652

Office Use Only
#_____QTR/YR:_____
Approved Amount:_____
Not Approved:_____
Ck request date:_____
DDP1 add date:_____

Date of Application: _____

Application Completed By: _____

Name of Applicant: _____
Individual with disability

Address: _____ _____ _____ _____
Street City State Zip Code

Phone Number: _____ **Gender : Male** ☐ **Female** ☐

Date of Birth: _____ **Tabs Number:** _____

Persons Living in the Home: _____ _____
Parent/Guardian (First, Last) Contact Number

_____ _____
Parent/Guardian (First, Last) Contact Number

The total number of siblings, under the age of 18 residing in the same residence (Do not include applicant) = _____

Disability Information:
Mental Retardation ☐ **Cerebral Palsy** ☐ **Epilepsy** ☐ **Autism** ☐ **Down Syndrome** ☐
Visually Impaired ☐ **Spina Bifida** ☐ **TBI** ☐ **Hearing Impaired** ☐
Other: _____
Any other medical concerns (shunts, pacemakers, et cetera): _____
_____
Adaptive equipment already used (eye glasses, hearing aids, AFOs, et cetera): _____
_____

Is the applicant currently enrolled in Self Directed Services? **Yes** ☐ **No** ☐ **Pending** ☐
Is the applicant currently enrolled in HCBS Waiver? **Yes** ☐ **No** ☐ **Pending** ☐

Please list any DSS Services received by applicant (food stamps, HUD, et cetera): _____
_____
_____

Medicaid Service Coordination Information:

Name: _____

Phone: _____ **E-Mail Address:** _____

Agency Name: _____

Agency Address: _____ _____ _____ _____
Street City State Zip Code

REQUEST FOR GOODS OR SERVICE: **(COMPLETE JUSTIFICATION BELOW)**

***A minimum of three estimates is required for applicable items (furniture, adaptive equipment, appliances, etc.)**
***A denial letter from Medicaid, private insurance or Waiver service is also required for any applicable items (adaptive equipment, environmental modification, medical procedures, etc.)**

Amount Requested

Item or Service Requested:_____ **$**_____

Name & Phone Number of Service Provider: _____ _____
Name **Phone Number**

What amount (or percentage) is the Family able to contribute?_____

REQUEST FOR RESPITE REIMBURSEMENT : **(COMPLETE JUSTIFICATION BELOW)**

Amount Requested
$_____

What amount (or percentage) is the Family able to contribute?_____

Please complete this section if you are requesting respite reimbursement

_____ _____
Name (Respite Worker) **Phone**

Please check if receiving: ☐ **Community Habilitation**
☐ **Hourly Respite**

If the applicant is authorized to receive Respite or Community Habilitation services please explain why respite funding is being requested:_____
_____
_____

REQUEST FOR RECREATION REIMBURSEMENT **(COMPLETE JUSTIFICATION BELOW)**

Amount Requested

Item Requested:_____ **$**_____

What amount (or percentage) is the Family able to contribute?_____

REQUEST FOR EMERGENCY FUNDING (please refer to grant guidelines): **(COMPLETE JUSTIFICATION BELOW)**

Amount Requested

Item Requested:_____ **$**_____

What amount (or percentage) is the Family able to contribute?_____

Justification for Grant. THIS SECTION MUST BE COMPLETED FOR ALL REQUESTS.
(Please attach an additional page if necessary):

_____
_____
_____
_____
_____
_____
_____
_____

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	$ Award amount	Date Received
		$	
		$	
		$	

Is the applicant currently applying elsewhere with this same request? Yes ☐ No ☐

Agency Name	Agency Phone #	Date Requested

Has the applicant applied to other agencies with this same request in the past and been denied? Yes ☐ No ☐

Agency Name	Date

Reason for Denial

Income Information:

Total Household Income per Year: $_____

Other sources of income not including working wages (SSI, SSD, Child Support, et cetera):

SSI/SSD: $_____ per month Child Support: $_____ per month

Other: $_____ per month Do you: Own ☐ Rent ☐ Other ☐

What additional expenses are related to the applicant's disability:_____

What health insurance do you/your family currently have? _____

Signatures (required):

Applicant	Date
Parent/Guardian	Date
Medicaid Service Coordinator	Date

Family and Child Service of Schenectady
FSS Grant Application Check List

(PLEASE RETURN WITH COMPLETED APPLICATION)

A W-9 tax form is required and must be completed when a recipients Grant Awards for the calendar year reaches $600.00 or more regardless of the number of grants and the types of grants.

☐ CONSUMER /MSC INFORMATION COMPLETE (MEDICAID, TABS, PHONE #'S, ADDRESS, ETC.)

☐ SIGNATURE OF CONSUMER OR PARENT/GUARDIAN (REQUIRED TO PROCESS)

☐ DDSO ELIGIBILITY DOCUMENTATION

☐ JUSTIFICATION FOR REQUEST

☐ PAID DOCUMENTATION (RECEIPT) IF REQUESTING REIMBURSEMENT FOR AN ITEM ALREADY PURCHASED

☐ 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.

☐ **EMERGENCY REQUEST:** FINAL SHUT OFF OR EVICTION NOTICE (WITH CONTACT INFORMATION) REQUIRED FOR ASSISTANCE WITH POWER, TELEPHONE OR RENT, ETC.

- **Application needs to be legible and completed in full to be submitted for review.**
- **The MSC of the applicant will be notified of incomplete applications at the convenience of the Director of Family Support Services.**

_____ _____
Signature of person completing application Date

_____ _____ext. _____
Agency Phone

_____
E mail address

2017 FSS GRANT COMMITTEE MEETING SCHEDULE

FOR

FAMILY & CHILD SERVICE OF SCHENECTADY

JANUARY 24, 2017 - GRANT COMMITTEE MEETING DATE

APPLICATIONS DUE BY JANUARY 12, 2017

APRIL 19, 2017 - GRANT COMMITTEE MEETING DATE

APPLICATIONS DUE BY APRIL 6, 2017

JULY 25, 2017 - GRANT COMMITTEE MEETING DATE

APPLICATIONS DUE BY JULY 13, 2017

OCTOBER 18, 2017 - GRANT COMMITTEE MEETING DATE

APPLICATIONS DUE BY OCTOBER 5, 2017

FSS GRANT APPLICATIONS RECEIVED AFTER THE QUARTERLY DUE DATE WILL BE SUBMITTED FOR THE FOLLOWING QUARTERLY COMMITTEE MEETING DATE.

TONI WAKEFIELD, DIRECTOR OF FAMILY SUPPORT SERVICES
372-2814 OR twakefield@familyandchildservice.com