Family & 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 Service (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 Developmental 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 emergency funding. (Please refer to guidelines for each grant request.)

Requests for grants are submitted to the FSS Program Director. The grant application must be completed in full and be accompanied with all required attachments (see application checklist). Each calendar quarter, the FSS Grant Committee reviews grant requests and make the determination to either approve or deny those grant request. This voluntary committee is made up of family members of individuals with developmental disabilities.

2018 FSS GRANT DUE DATES

Applications due by **January 11, 2018** for 1st quarter meeting
Applications due by **April 12, 2018** for 2nd quarter meeting
Applications due by **July 19, 2018** for 3rd quarter meeting
Applications due by **October 11, 2018** for 4th quarter meeting

FSS grant applications received after the quarterly due date will be submitted for the following quarterly committee meeting date.

FCSS Family Support Services Grant/Reimbursement Program Guidelines

Respite

- The total dollar amount of FSS **respite reimbursement** grant funding approved per individual, 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.
- **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 individuals 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 lessons, etc. may be awarded **two (2) times per calendar year. These will only be considered in the 1st, 2nd, and 3rd quarters of the year.** The award amount may be up to 12 sessions but not to exceed a total reimbursement of $750.00 per calendar year.
- Requests for clothing or related items must be related to the individual'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).

- Requests for food must be related to the individual's disability. (e.g. special diet, gluten free or foods otherwise not covered by Medicaid).
    - 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).

Recreation

- Grant requests for **recreation funding** will be awarded **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).

Emergency Funds

- The requests are solely for urgent need of **imminent eviction** or **cancellation of utilities**: electric and/or heating source that presents a significant threat to the health and safety of the individual.
- Requests must:
    - Verify impending eviction or termination of services from the appropriate vendor.
    - Provide current utility statement/shut off notice.
    - Verify that all other payment options have been exhausted (e.g. HEAP, budget plans, DSS, etc.)
    - A written action plan completed by the family to avoid further emergency situations must be submitted with the application.
- Rental assistance is limited to (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.**
    - Requests can be submitted at any time throughout the year.
    - A determination will be made of approval or non-approval approximately within a two week period.

FSS Grant Application Check List

- ☐ Consumer/MSC Information complete (Medicaid, Tabs, Phone Numbers, Address, etc.)
- ☐ Signature of individual or parent/guardian (required to process)
- ☐ DDRO eligibility documentation
- ☐ Justification for request
- ☐ Paid documentation (receipt) if requesting reimbursement for an item already purchased
- ☐ Denial letter from Medicaid, private insurance or waiver service (environmental modification of adaptive technology, if applicable)
- ☐ Name and phone number of provider if requesting a service such as respite reimbursement, piano lessons, music therapy, etc.
- ☐ Self Direction Plan/Budget Attached (if applicable)
- ☐ **Emergency Request:** Final shut off or eviction notice (with contact information)

General Information

- **When a recipient's Grant Award(s) for the calendar year reaches or exceeds $600.00 a W-9 tax form will be issued with instruction for completing it. The W-9 form must be completed by the applicant, family and/or caregiver and returned within two (2) weeks.**
- 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 through those sources. These requests require a denial letter from the funding source and must be submitted with the grant application.
- All requests must conform to NYS OPWDD guidelines and regulations.
- 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 individual may be subject to partial funding approval (e.g. washer, dryer, couch, etc.)
- Requests that identify a possible risk and liability to the individual will not be approved (e.g. pools, trampolines, etc.)
- Participants agree that they are solely responsible for any accident or injury related to a grant supported activity or goods and service.
- They also agree to "hold harmless" FCSS for any accident or injury sustained by any individual related to a grant supported activity or goods and services.
- 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.**
- 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
- When a gift card and/or reimbursement check is sent to the MSC it is the responsibility of the MSC: to distribute the award, assist or accompany the family in making the purchase, and return the receipt for the purchase made to FCSS. 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;

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

Sliding Scale

- The amount of the families 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:

ID ☐ **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** ☐
Broker Contact Information: _____

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 FOR THIS REQUEST BELOW)**

***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 FOR THIS REQUEST BELOW)**

Amount Requested

$ _____

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

The name and phone number must be completed in order to be considered for funding.

_____ _____

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 FOR THIS REQUEST 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 FOR THIS REQUEST 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**

Please note, by completing and signing this application, you give permission for Family and Child Service of Schenectady to contact other agencies regarding your reimbursement requests.