Dear Family Member/Caregiver:

Living Resources Corporation’s Family Support Services (FSS)—Family Reimbursement for Goods & Services program provides financial assistance to families in New York State who live with a family member diagnosed with a developmental disability. This service can provide financial reimbursement to families who have had to buy necessities for their loved one with ID/DD, up to $200 per family each year. The Family Support Services (FSS) Coordinator brings together a committee consisting of programming staff and family members of people receiving OPWDD services to review applications for reimbursement. Reimbursement grants are distributed to approved applications on a quarterly basis.

Applications must be turned into our office by the following dates in order to be considered for approval:

- Quarter 1: Friday, February 15th, 2019
- Quarter 2: Friday, May 17th, 2019
- Quarter 3: Friday, August 16th, 2019
- Quarter 4: Friday, November 15th, 2019

The committee takes into consideration any special request regarding these deadlines as long as the recipient contacts the FSS Coordinator to review the circumstances on an individual basis.

Requests are reviewed on an anonymous basis; only the FSS Coordinator will know applicants’ names for proper dispersal of funds. Decisions are based on the following: eligibility for OPWDD services, financial need of the applying family, the necessity of the item for which the family seeks reimbursement, previous grants received by the family, and how the grant will improve the individual’s and family’s quality of life. Anyone submitting an application will need to include the following:

- A completed grant application
- A detailed justification for the request
- If you are requesting a service or item, the agency requires a statement from the vendor stating the cost of the item/service and mailing address
- For items already purchased, please include the receipt with your application (We cannot pay for items purchased prior to the current approval year)
- Families who are new to OPWDD funded Family Support Services must now connect with their Front Door Liaison
- Families who are in Self-Direction must note that on the application and include broker information. Self-Direction Budget amendments must be submitted to Living Resources Corporation should the individual receive a grant.
After the FSS Family Reimbursement Committee has met, the agency will contact you via mail as to the decision of the committee. Letters of approval or denial will be generated within one month of the meeting date. Unfortunately, we are not always able to approve all requests.

Thank you for applying to Living Resources Corporation for a FSS grant. Please contact Jacqueline Calder, FSS Coordinator, at jcalder@livingresources.org or at 518-218-0000 ext. 5414 with any questions or assistance needed in completing the application.

Best,

[Signature]

Jacqueline Calder, QIDP
Family Support Services (FSS) &
After School Program, Manager
Living Resources Corporation
300 Washington Avenue Extension
Albany, New York 12203-7303
E: jcalder@livingresources.org
P: 518-218-0000 ext. 5414
C: 518-209-8595
F: 518-862-2175
Application for Family Support Services—Family Reimbursement for Goods & Services Grant, 2019

Name of Applicant (Person with OPWDD Eligibility):

Street Address:

City: State: Zip Code:

DOB: ___________________________ Gender: Male / Female / Other (please circle one)

SSN: ___________________________ Medicaid #: _______________ TABS ID: _______________

Persons Living in the Home (only parent(s)/guardians and children under 18):

Parent/Guardian (First & Last Name):

Telephone Number: E-mail Address:

Parent/Guardian (First & Last Name):

Telephone Number: E-mail Address:

Parent/Guardian (First & Last Name):

Telephone Number: E-mail Address:

Children Under 18 (do not include applicant):

Name: Relationship: Age:

Name: Relationship: Age:

Name: Relationship: Age:

Name: Relationship: Age:

Name: Relationship: Age:

Family’s Annual Gross Income (including SSI/SSDI):

Contacted Front Door Liaison? (Please circle one) Yes / No / N/A Date:

Enrolled in Self-Direction? (Please circle one) Yes / No / Not Yet / In the Process

If “Yes” or “In the Process”: Broker Name & Contact:

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

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<thead>
<tr>
<th>Agency Name</th>
<th>Phone Number</th>
<th>Date Requested</th>
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*Please note that by completing this application, you give permission to Living Resources Corporation to contact other agencies regarding your reimbursement request.*
Care Manager Information (best completed by or with the Care Manager):

Is the applicant enrolled in the Medicaid Waiver? Yes / No / Pending (please circle one)

Care Manager’s Name: ___________________________  Phone #: ___________________________
Agency Name: ___________________________  Street Address: ___________________________
City: ___________________________  State: ___________________________  Zip Code: ___________________________
E-mail Address: ___________________________

Please list any other Waiver and/or Respite Services the applicant receives:

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Agency Providing Service</th>
<th>Contact Person &amp; Information</th>
<th>Frequency the service is received</th>
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</thead>
<tbody>
<tr>
<td>Care Management</td>
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<td>Community Habilitation</td>
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<td>In-Home Waiver Respite</td>
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<td>Free Standing Respite</td>
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<td>Early Intervention</td>
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<td>Day Program</td>
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Disability Information: Please check those that apply:
Intellectual Disability____  Cerebral Palsy____  Epilepsy____  Autism____  TBI____
Down Syndrome____  Visually Impaired____  Hearing Impaired____  Spina Bifida____
Other________________________

Any other medical concerns:
________________________________________
________________________________________
________________________________________
________________________________________
________________________________________
________________________________________

Please indicate any major shifts in the family dynamic within the past year that has caused undue hardship (ex: loss of a job, hospitalization, death, etc):
________________________________________
________________________________________
________________________________________
________________________________________
________________________________________
________________________________________
________________________________________
Other Grant Information:

Please list all grants that the applicant has received since the beginning of the current calendar year:

<table>
<thead>
<tr>
<th>Item(s) Received</th>
<th>Agency Name</th>
<th>Cost of Item</th>
<th>Date Received</th>
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Has the applicant been denied for this request this calendar year? Yes / No (please circle one)

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Reason for Denial

What expenses do you have related to your family member’s disability?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

What health insurance do you/your family currently have?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Specify the service/item you are requesting by checking the appropriate line below:

Personal Care Supplies________  Environmental Modifications________
Tuition or fees to a program (ex: camp)________  Tutor________  Adaptive Equipment________
Other (specify)________________

Amount Requested $_________  Price of Item: $_________
If your current request is for Adaptive Equipment, Environmental Modifications, or Medical Requests/Services, you will need to include:
  o Adaptive Equipment: A minimum of three estimates for applicable items
  o Adaptive Equipment, Environmental Modifications, Medical Requests/Services:
    o a denial letter from Medicaid, private insurance, or Waiver Service for applicable items
    o A note from a doctor/clinician supporting the service denied by Medicaid/private insurance

Please describe in detail how this service/item would enhance you and/or your family’s life (include additional pages if needed)

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Signature (required):

Applicant                        Print Name                        Date

Parent/Guardian                  Print Name                        Date

Care Manager                     Print Name                        Date