Community, Work & Independence, Inc.
16 Pearl Street • P.O. Box 303 • Glens Falls, NY 12801
phone: 518.793.4700 • fax: 518.745.1413

2022 Family Reimbursement Application for Goods and Services
(Non-Respite Supports)

☐ INDIVIDUAL /CARE MGR. INFORMATION COMPLETE (MEDICAID, TABS, PHONE #'s, ADDRESS)
☐ SIGNATURE OF INDIVIDUAL OR PARENT/GUARDIAN (REQUIRED TO PROCESS)
☐ DDRO ELIGIBILITY DOCUMENTATION
☐ JUSTIFICATION FOR REQUEST (**including clinical reports for therapy or adaptive equipment assistance** requests)
☐ PAID DOCUMENTATION OF REIMBURSEMENT REQUEST FOR SERVICES or items ALREADY PROVIDED during 2022 (receipts must be dated in current approval year.)
☐ (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 PIANO LESSONS, MUSIC THERAPY, TUTORING, ETC

- **Application needs to be legible and completed in full to be submitted for review. Submitting applicants will be notified of incomplete applications at the convenience of the program director.**

_____ _____
Signature of person completing application Date

_____ _____
Agency Phone/Ext.

E mail address: _____

Please return completed applications to:

Andrea Colvin
Community Services Manager
CWI, PO Box 303, Glens Falls, NY 12801
Phone: 793-4700 Ext. 19142
Email: acolvin@cwinc.org

Please feel free to reach out with any questions:
(518)793-4700 ext. 19142

For Office Use:
Date Application Rec._____
Date DDP1 Completed: ____
Committee Approval
Date: ____

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APPLICATION FOR FAMILY REIMBURSEMENT GRANT 2022
(Goods and Services)

Name of Applicant (Person with Disability): _____

Street Address: _____

City: _____State: _____ Zip Code: _____

DOB: _____ Gender: _____ SSN: _____

Medicaid #: _____ TABS ID: _____

Persons living in the Home (only parent(s)/guardian(s) and children under 18):

Parent/Guardian: _____

Home phone: _____ Work/Cell: _____

Parent/Guardian: _____

Home phone #_____ Work/Cell: _____

Email Address _____

***Children under** 18 (do not include applicant):*

Name: _____Relationship: _____Age: _____

Name: _____Relationship: _____Age: _____

Name: _____Relationship: _____Age: _____

Name: _____Relationship: _____Age: _____

Contacted Front Door Liaison? ☐ YES ☐ NO ☐ N/A Date_____

Enrolled in Self Direction? YES ☐ NO ☐
Broker Contact Information: _____
Is the Self Direction Budget attached? YES ☐ NO ☐ (A copy of the Self Direction budget with CWI listed as FSS provider must be provided)

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Care Manager Information:

Is the applicant enrolled in Medicaid Waiver? Yes☐ No☐ Pending☐

Care Manager's Name: _____

CCO Name_____ Phone#: _____

Street Address: _____

City: _____State: _____ Zip Code: _____

Email Address: _____

***Please list any Waiver or Other Services the applicant receives*:**

Type of Service	Agency Providing Service	Contact Person and Phone Number	How often is this service currently being provided?
Early Intervention			
Care Coordination			
Community Habilitation			
Waiver Respite Hourly☐ Site-Based☐ Recreational☐ Other☐			
Free Standing (Out of Home) Respite			
School			
Day Program			
Other-please explain			

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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 shift in the family dynamic within the past year that has caused undue hardship (i.e. Loss of a job, hospitalization, death etc.), if applicable.
_____

Other Grant Information:

****Please note, per the Capital District DDRO, a family can only work with one Family Empowerment Grant provider at a time. Maximum Award: $ 1,200/ year for goods and services (effective 1/2022)**

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

ITEM(S) RECEIVED	AGENCY NAME	COST OF ITEM(S)	DATE RECEIVED

Is the applicant currently applying elsewhere with this same request: Yes / No
Please note, by completing this application, you give **permission** for CWI staff to contact other agencies regarding your reimbursement requests.

AGENCY NAME	PHONE #	DATE REQUESTED

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

_____

What health insurance do you/your family currently have?

_____

Current Request:

- A minimum of three estimates is required for applicable items (adaptive equipment) * A denial letter from Medicaid, private insurance or Waiver Service is also required for applicable items (adaptive equipment, environmental modifications, and medical request/services.
- *A note from Dr's/clinicians supporting the service denied by Medicaid/private insurance (Speech, OT etc.)
- All camps must be permitted by NYS or local health department. Camps must be in NYS for reimbursement approval.

Specify the service you are requesting by checking below:

☐ **Personal Care Supplies** ☐ **Environmental Modifications**

☐ **Tuition or fees to a program (ex: camp)** ☐ **Tutor** ☐ **Adaptive Equipment**

☐ **Other (specify)** _____

Amount Requested$_____ **Price of item: $**_____

Are you able to contribute any amount toward the item/how much?

YES ☐ **NO** ☐ **If YES, how much** **$**_____

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

_____

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Signature (Required):

Applicant	**Print Name**	**Date**
Parent/Guardian	**Print Name**	**Date**
Care Manager	**Print Name**	**Date**

Thank you for your application! If you are approved-you will receive written notification in the mail.