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 Empowerment Respite Grant Application Check List

(PLEASE RETURN WITH COMPLETED APPLICATION) INDIVIDUAL /CARE MGR. INFORMATION COMPLETE (MEDICAID, TABS, PHONE #'s, ADDRESS)

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

☐ OPWDD ELIGIBILITY DOCUMENTATION

☐ JUSTIFICATION FOR REQUEST (including clinical reports if applicable.)

☐ NAME & PHONE NUMBER OF PROVIDER IF REQUESTING A SERVICE

- **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 Community Services Manager.**

______________________________ ______________
Signature of person completing application Date

______________________________ ______________
Agency (if applicable) Phone/Ext

E mail address: ______________________________

Please send completed applications to:

Andrea Colvin
Community Services Manager
PO Box 303
Glens Falls, NY 12801
Email: acolvin@cwinc.org

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

For Office Use:
Date Packet Rec.:________
Is the packet complete?:__________
Date DDP1 Complete: ___________
Committee Approval Date: ______

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APPLICATION FOR FAMILY REIMBURSEMENT RESPITE GRANT

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 ☐

Please note that a copy of the Self-Direction budget with CWI listed as an FSS provider must be included to process payment

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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 other Waiver and/or Respite 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			
Hourly Waiver Respite Recreational Respite Site Based Respite Camp Respite Intensive Respite			
Free Standing (Out of Home) Respite			
School			
Day Program			

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Other – please explain			

Disability Information:

Please check those that apply:

Intellectual Disability ☐	Autism ☐	TBI ☐	Epilepsy ☐
Cerebral Palsy ☐	Spina Bifida ☐	Visually Impaired ☐	Hearing Impaired ☐
Down Syndrome ☐	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 receive a Family Empowerment Grant Provider at a time. Maximum Award: $ 3,000/ year for respite (effective 1/1/2022)**

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   Date Received

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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

Has the applicant been denied for this request this calendar year: Yes ☐ No ☐

____
AGENCY NAME PHONE # DATE REQUESTED

____
Reason for Denial

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

____

What health insurance do you/your family currently have?

____

Respite Reimbursement Amount Requested ___________________________________

Please explain why FSS Respite Reimbursement is necessary (REQUIRED):

____

____

Signature (Required):

____
Applicant **Print Name** **Date**

____
Parent/Guardian **Print Name** **Date**

____
Care Manager **Print Name** **Date**

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