WILDWOOD
Family Reimbursement Grant Application
2020

Name of individual in need of support: _____

Age: _____ Date of Birth: _____ Gender: ____ TABS #: _____

Name of Parent(s)/Caregiver(s): _____

Street Address: _____

City: _____ State: ____ Zip Code: _____ County: _____

Phone #: (____) _____ Email: _____

Nature of Individual's Disability**: (please indicate all that apply)**

☐ Intellectual Disability ☐ Neurological Impairment ☐ Autism
☐ Cerebral Palsy ☐ Seizure Disorder ☐ Developmental Delay
☐ Other (Please Specify) _____

Please indicate the OPWDD and/or Waiver services you are currently receiving:

☐ Care Coordination ☐ Respite ☐ Community Habilitation ☐ SEMP ☐ Day Hab
☐ Self-Direction: Applied: _____ or Launch Date: _____ or
Budget Effective Date: _____

Name of Care Manager: _____
CCO: _____ Phone #: _____
E-mail: _____

Complete the following checklist before submission:

☐ **Letter of Eligibility from OPWDD must accompany this request**
☐ Receipt for pre-purchased item(s) if requested
☐ Family member lives at home with parent(s)/caregiver(s)
☐ Parent/Caregiver has signed application
☐ Self-Direction budget must be attached if applicable and include Contracted Services -FSS funds must be allocated to Wildwood

Administrative Use Only

Program Name: Reimbursement #4102 *Client #_____*

Approval Date: _____ *Approved/ Amount: _____ Denied_____ Reason_____*

Contact made with family: *Letter: _____ Phone Call: _____ CM Contact:_____*

Staff Initials: _____

Please check which you are applying for: ☐ **Respite** **or** ☐ **Goods and Services**

Respite

If applying for respite reimbursement, please explain the reason for this request.

_____

_____

_____

If applying for Respite, has a staff person been identified? ☐ Yes or ☐ No
Note: Providers may be a family member but CANNOT have the same address as the individual, or be a parent.

If no staff is identified, what is your plan to secure staffing to put this grant to use?

_____

Total Amount of Request for Respite: $_____

Goods/Services

Please describe the service or item for which you are requesting reimbursement and how it will benefit your child. You may attach an additional sheet if necessary.

_____

_____

_____

_____

Total Amount of Request: $_____
Please attach a written estimate from the company/store for the item.

Range of gross family income (check one):	Please indicate the number of individuals in your home:
☐ Under $29,999 ☐ $30,000 - $49,999 ☐ $50,000 - $79,999 ☐ $80,000 - $99,999 ☐ $100,000 - $149,999 ☐ $150,000 and Higher	_____ Adults - Age 18 and older _____ Minors - 17 years old and younger

Is the applicant currently applying elsewhere for this request? ☐ Yes or ☐ No
If Yes: Agency: _____
Contact: _____

Please note: By completing this application, you give Wildwood Programs staff permission to contact other agencies regarding this reimbursement request.

_____ _____
Parent/Caregiver Signature* Date

***Parent/caregiver must sign the application in order for the reimbursement request to be considered.**

Return Application to:
Wildwood, Family Reimbursement Grant Program, 1190 Troy Schenectady Rd., Latham, NY 12110
Fax: 518-640-3307 - Email: HGiorgianni@wildwoodprograms.org