1190 Troy-Schenectady Rd
Latham, New York 12110
P:(518)640-3300
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wildwoodprograms.org

WILDWOOD
Family Reimbursement Grant Application
2021

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.

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