Wildwood Programs
Family Reimbursement Grant
2022 Application

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 check off the OPWDD Waiver Services you are currently Approved for, and write an R next to those you are receiving:

☐ Care Management__ Respite__ Community Habilitation__ SEMP__ Day Habilitation__

☐ Self-Direction: Applied: ___________ or Budget Effective Date: _____________ _

Name of Care Manager: ____

Name of 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
☐ If Self Directed, Approved Self-Direction budget is attached and includes Contracted Services - FSS funds must be allocated to Wildwood Programs

Administrative Use Only

Program Name: Reimbursement #4102

Approval Date: __________ *Amount Approved:* _______ *Denial Reason:* _________________________

Contact Made with family
Letter Sent: __________ *Phone Call:* __________ *CM Emailed/Called:* ______________

Staff who entered in Consumer Database: ________ *CHOICES:* _________

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.

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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 is related to your child's disability. You may attach an additional sheet if necessary.

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Total Amount of Request: $_____________ ******Please attach a written estimatefrom the company/storefor the item.*

Range of gross family income (check one):	Please indicate the number of individuals in your home:
☐ *Under $29,999* ☐ *$30,000 - $59,999* ☐ *$60,000- $89,999* ☐ *$90,000 - $119,999* ☐ *$120,000 - $149,99* ☐ *$150,000 and Higher*	_________ *Adults -Age 18 and older* _________ *Minors - 17 years old and younger*

_______________________________________ ________________

Parent/Caregiver Signature* Date

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

Return Application to:
Wildwood Programs
Family Reimbursement Program
1190 Troy Schenectady Rd., Latham, NY 12110

Fax: 518-640-3307 - Email: HGiorgianni@wildwoodprograms.org