ADAPT COMMUNITY NETWORK
80 MAIDEN LANE, 8TH FL, NEW YORK, NY, 10038
212-683-6700 EXT 1172
DANIELLE RAYMOND
DIRECTOR, FAMILY REIMBURSEMENT
FAMILY REIMBURSEMENT FUND
DRAYMOND@ADAPTCOMMUNITYNETWORK.ORG

APPLICATION FOR GOODS AND / OR SERVICES

ALL APPLICATIONS THAT ARE NOT COMPLETE WILL BE RETURNED

THIS APPLICATION IS FOR MANHATTAN RESIDENTS ONLY

AWARDS ARE NOT GUARANTEED

The approval process can take up to 3 months

We must be given a complete address, including an apt number/private residence, and zip code. We will not reissue checks if the address is not complete.

Family Reimbursement applications should be requested at the beginning of EACH fiscal year, July 1st. Old applications will be returned to sender.

Eligibility for Adapt Community Network Family Reimbursement

There must be a family member with a developmental disability and the individual must be living with a family member. The individual must be eligible for OPWDD services.

The merchandise or service requested must only be for the benefit of the person who has a developmental disability.

FISCAL YEAR:
STARTS July 1 and ends June 30. All applications and receipts must be dated within the current fiscal year. We can only accept original itemized receipts. We cannot accept generic or handwritten receipts for clothing.

ALL APPLICATIONS MUST INCLUDE A DETAILED STATEMENT OF NEED. Please be sure to sign and date. (Why this family should be reimbursed)

CAMP FUNDING:

Manhattan residents must apply for camp funding through other agencies. We do NOT provide camp reimbursement for Manhattan residents.

Please Note:

Justification letters from a doctor or therapist must be written on letterhead, signed, and include a license number. We must receive the original letter, WE CANNOT ACCEPT COPIES.

If you have financed an item, you must pay off the balance before applying for reimbursement.

We cannot reimburse for services that have not yet taken place, such as soccer classes, swim lessons, karate classes, etc. You must pay out of pocket first, and then apply for reimbursement after all lessons/classes have taken place.

Adapt Community Network
80 Maiden Lane, 8th Fl,
New York, NY 10038
FAMILY REIMBURSEMENT APPLICATION
Awards are not guaranteed, and are contingent on the availability of funds.
Awards are distributed quarterly

INCOMPLETE APPLICATIONS WILL BE RETURNED

Please answer all questions **Please print**

CONSUMER INFORMATION

Date:_____

Name of Person with Disability:_____
TABS #_____
Current Address:_____Apt #:____Private Residence:_____
City_____ Zip Code_____
Phone #:_____Date of Birth:_____
Individuals size*:_____(e.g. 1T, S/M/L, 0, 2, and Up) Shoe size: _____
SS#_____ Medicaid #_____
Telephone # of Service Coordinator_____
Which developmental disability does the person have: _____

PURCHASE INFORMATION

If purchase has already been made, **original** receipt **MUST** be attached.
All of the questions in this section **must be answered.**
What item(s), service(s) do you want reimbursement for? Please specify:_____
What is the total cost? $_____
What amount are you asking to be reimbursed for? $_____
Has this item already been paid for? _____
Specify all other ways of paying for item(s) and/or service(s) you have tried, before making this request:

FAMILY INFORMATION

Name of Parent/Guardian:_____
Relationship to Individual_____ Email Address:_____
Number of Members in Household_____ Number of family members employed:___
_____

Where do you reside? Home_____ Residence_____Foster Care:_____

Total Family Income:$ _____

Are there other circumstances that affect your family's finances?

Explain._____

_____

_____

OTHER INFORMATION

Have you received any type of reimbursement within the last year: Yes [ ] No [ ] If yes,

please specify: Agency_____ Amount $_____ Purpose_____

Date rec'd _____

Have you/are you going to apply to other agencies for reimbursement for this request?

Yes ( ) No ( )

If yes, please specify: Agency:_____When and/or date of application:_____

As of this date, have any of these agencies committed to partial or full reimbursement of this request?

Yes ( ) No ( ) If yes, please specify: Agency:_____Amount: _____

I have attached my original receipts and supporting documents where necessary.

PERSON FILLING OUT APPLICATION TO COMPLETE THE FOLLOWING.

Name:_____Signature_____

Address:_____

Phone Number:_____Relationship to Individual_____

APPLICATIONS NOT COMPLETELY FILLED OUT WILL BE RETURNED
THE APPROVAL PROCESS CAN TAKE UP TO 3 MONTHS

ADAPT COMMUNITY NETWORK

STATEMENT OF NEED:
WHY IS THIS GOOD/SERVICE NEEDED? PLEASE BE SURE TO EXPLAIN ANY SPECIAL CIRCUMSTANCES THAT EFFECT YOUR FAMILY'S FINANCIAL SITUATION.
THIS FORM MUST BE FILLED OUT FOR ALL REQUESTS

ADAPT COMMUNITY NETWORK

Family Reimbursement Program-Claim Form for Hourly Respite Services

If you are requesting reimbursement for hourly respite services please send use this form and submit with the following:
1) A detailed written explanation why you needed help
2) Proof of payment such as a cancelled check or money order stub
3) This form must be signed by the parent or guardian and the respite worker and must be notarized.
Complete this form following the given example below:

Date	Day of the Week	Hours of Work	Hourly Rate	Workers Name Print	Parent's Signature
1/1/01	*Monday*	*4*	*11.50*	*Jane Doe*	*In Blue Ink*

*** Maximum is $10.00 per hour**
I verify that the above listed services were received

Respite Worker's Signature **Parent or Guardian's Signature**

Address of Respite Worker

Notary Information:

Please return completed application to:

Danielle Raymond
Director, Family Reimbursement
80 Maiden Lane, 8th Fl,
New York, NY, 10038