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  

Name of Person with Disability:  
Date:  

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:  

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3
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

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5
Family Reimbursement Program-Claim Form for Hourly Respite Services

If you are requesting reimbursement for hourly respite services please 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:

<table>
<thead>
<tr>
<th>Date</th>
<th>Day of the Week</th>
<th>Hours of Work</th>
<th>Hourly Rate</th>
<th>Workers Name</th>
<th>Parent’s Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/1/01</td>
<td>Monday</td>
<td>4</td>
<td>11.50</td>
<td>Jane Doe</td>
<td>In Blue Ink</td>
</tr>
</tbody>
</table>

* 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