ADAPT COMMUNITY NETWORK
80 MAIDEN LANE, 8TH FL, NEW YORK, NY10038
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 QUEENS 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 application 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.

According to OPWDD Family Support Services guidelines, it is imperative that all applications contain documentation of a developmental disability.

Please submit one of the following:

1. Psychological Evaluation
2. Notice of Decision
3. Level of Care

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 receipts must be dated within the current fiscal year, and must be clear and legible, and itemized. The application and any estimates or justification letters for goods or services must also be dated within the fiscal year.

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

CAMP FUNDING:

If you are seeking funds for Waiver funded camps such as HASC, Camp Oakhurst and The Children's Aid Society "Wagon Road Camp" you must provide a letter from the camp attesting that no waiver funds are used for the camper, or the reimbursed services are over the waiver fund amount.

Statements from JBFCS and The SHMA Camps must include a breakdown of the amounts paid by the Board of Education.

The camp statement must be an original. The camp statement or invoice MUST show the camp start and end date and MUST be dated within the current fiscal year.

Depending on when the application is up for approval, it could take 3 to 6 months, an updated bill may be requested.

If you are asking for reimbursement for camp payment, you must provide a copy of the camp statement showing a zero balance and proof of payment such as a copy of a cancelled check or credit card statement.

RESPITE:
Respite will be considered for emergencies only, such as a hospitalization or death in the family. You must use Adapt Community Network's respite form to document respite care. The form MUST be notarized and signed by the family member and the caregiver. The caregiver must also provide their address.

UTILITY/ RENT PAYMENTS:
Utility:
The family must provide the original current bill as well as a letter from the MSC with justification for no-payment. Bill must indicate "Final notice or shut-off notice."

Utility/Rent:
You must have applied and received denial for a One Shot Deal prior to applying for reimbursement. Proof of denial must be submitted with the application as well as proof that family will be able to support costs going forward.

BEDS
Families may claim reimbursement for a **TWIN** size bed only unless medical justification can be provided for the need of a larger bed.

BED BUG INFESTATION:
You must provide the original bill from a licensed exterminator showing treatment was done and a later inspection to show that the home is bed bug free.

RECEIPTS:
We can only accept original itemized receipts**. We cannot accept generic or handwritten receipts for clothing**. The receipts must be dated within the current fiscal year. If clothing is purchased online, you must provide additional proof of payment such as the credit card/bank statement showing the purchase and the cardholder's name.

THERAPUTIC ITEMS/SERVICES:
If the request is for a therapeutic item, clinical documentation from a licensed professional explaining why the item/service is necessary and how it would benefit the individual with the disability, must be included. The documentation must include the physicians stamp and license number and must be the original. We **do not** accept photocopies.

MEDICAL AND ADAPTIVE EQUIPMENT:
If the request is for medical or adaptive equipment, medical documentation supporting a need for the equipment must be included. The documentation must include the physicians stamp and license number and must be the original. We do not accept photocopies. You must also show proof that Medicaid or your medical insurance does not cover the item.

AIR CONDITIONERS
All requests for air conditioners must be accompanied with an original doctor's justification. The AC must be 8,000BTUs or less.

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.

We cannot reimburse for food or toys.

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

We cannot reimburse for services that not have not yet taken place, such as soccer classes, swim lessons, karate classes, etc (with the exception of summer camp). 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**

INDIVIDUAL 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 #_____
If the disabled individual receives services from an agency please list:
Name of Agency:_____Phone #_____
Name of Program Contact Person:_____
Services Received:_____
Telephone # of Case Manager_____
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? $_____How much can you contribute? $_____
What amount are you asking to be reimbursed for? $_____
Specify all other ways of paying for item(s) and/or service(s) you have tried, before making this request:
Please name all traditional means attempted as per attached page and affix all supporting documents.

_____

What were the results of your efforts?_____

If your application is approved, the check will be made out to the person or vendor. List name of person or vendor:

_____

APPLICATIONS NOT COMPLETELY FILLED OUT WILL BE RETURNED

The approval process can take up to 3 months

FAMILY INFORMATION:

Name of Parent/Guardian:_____
Relationship to Individual_____ Email Address:_____

Number of Members in Household_____
Does the family (Individual and Caretakers) receive any of the following? (**CHECK ALL THAT APPLY**)**Medicaid [ ] Medicare [ ] SSI [ ] Public Assistance [ ] WIC [ ] AFDC [ ] Food Stamps [ ]Unemployment Income [ ] Disability Income [ ]**
Total amount of benefits per household, per month: $_____
Number of family members employed:_____

Total Family Income: $1-$24,999.00( ) $25,000- $49,000( ) $50,000-$74,999( ) $75,000-

$99,000( ) $100,000 and over( )_

Do you have health insurance coverage:_____ Is Individual covered?_____

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: _____
If your application is approved, the check will be made out to the person or vendor. List name of person or vendor:_____

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_____

STATEMENT OF NEED:

WHY IS THIS GOOD/SERVICE NEEDED?

THIS FORM MUST BE FILLED OUT FOR ALL REQUESTS

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