

2010 FSS GRANT COMMITTEE MEETING SCHEDULE
FOR
FAMILY & CHILD SERVICE OF SCHENECTADY

JANUARY 21, 2010 (GRANT COMMITTEE MEETING)

APPLICATIONS DUE BY DECEMBER 31, 2009

APRIL 22, 2010 (GRANT COMMITTEE MEETING)

APPLICATIONS DUE BY APRIL 2, 2010

JULY 22, 2010 (GRANT COMMITTEE MEETING)

APPLICATIONS DUE BY JULY 2, 2010

OCTOBER 21, 2010 (GRANT COMMITTEE MEETING)

APPLICATIONS DUE BY OCTOBER 1, 2010

FSS GRANT APPLICATIONS RECEIVED AFTER THE QUARTERLY DUE DATE WILL BE SUBMITTED FOR THE FOLLOWING QUARTERLY COMMITTEE MEETING DATE.

PLEASE CONTACT TONI WAKEFIELD @ 372-2814 OR twakefield@familyandchildservice.com

Family and Child Service of Schenectady

FSS Grant Application Check List

(PLEASE RETURN WITH COMPLETED APPLICATION)

____ CONSUMER /MSC INFORMATION COMPLETE (MEDICAID, TABS, PHONE #'S, ADDRESS ETC.)

____ SIGNATURE OF CONSUMER OR PARENT/GUARDIAN (REQUIRED TO PROCESS)

____ DDSO ELIGIBILITY DOCUMENTATION

____ DDP1 (LEAVE SECTION 7, 8, 9 & 10 BLANK)

____ JUSTIFICATION FOR REQUEST

____ DOCUMENTATION OF REIMBURSEMENT REQUEST FOR SERVICES ALREADY PROVIDED

____ (3) ESTIMATES (IF APPLICABLE) INCLUDING VENDOR NAME & MAILING ADDRESS

____ DENIAL LETTER FROM MEDICAID, PRIVATE INSURANCE OR WAIVER SERVICE (ENVIORNMENTAL MODIFICATION OF ADAPTIVE TECHNOLOGY REQUIRED (IF APPLICABLE)

____ NAME & PHONE NUMBER OF PROVIDER IF REQUESTING A SERVICE SUCH AS RESPITE REIMBURSEMENT, PIANO LESSONS, MUSIC THERAPY, TUTORING, ETC.

____ FINAL SHUT OFF OR EVICTION NOTICE (WITH CONTACT INFORMATION) REQUIRED FOR ASSISTANCE WITH POWER, TELEPHONE OR RENT, ETC.

- **Application needs to be legible and completed in full to be submitted for review. Submitting applicants will be notified of incomplete applications at the convenience of the FSS Coordinator.**

Signature of person completing application

Date

Agency

_____ **ex** _____
Phone

E mail address

Family and Child Service of Schenectady, Inc.
246 Union Street
Schenectady, NY 12305
(518) 372-2814 or 393-1369 ex 51

Family Support Services Family Reimbursement Grant Application

Family and Child Service of Schenectady, Inc. provides FSS grants to families who reside with a family member diagnosed with a developmental disability residing in Schenectady, Albany, Saratoga, Schoharie, and Rensselaer Counties. Grants are available for the purpose of goods and services, respite reimbursement, or recreation.

Grants are distributed quarterly in the months of January, April, July, and October. Every quarter a grant committee, composed of family members related to a developmentally disabled consumer, reviews the requests and determines the approval or denial of grants. The committee reviews these requests on an anonymous basis. Decisions are based on the following: Waiver, Medicaid or private insurance funding denial, the need for the grant, previous grants received by the family, and how the grant will improve the individual's quality of life. The agency prioritizes consumers with Developmental Disabilities whose families are low income or experiencing severe financial distress.

Anyone wishing to submit a request must include the following:

- A completed grant application
- A detailed justification for the request
- A completed DDP1
- If you are requesting a service or item the agency requires a statement from the vendor stating the cost of the item/service, and mailing address.
- A signed photo release (optional). This is requested because the agency welcomes any photos of grant recipients using their grants. These pictures can be used in our justification of the grant program to OMRDD or they may be used for other purposes such as our newsletter. At times the agency also applies for private donations when the pool of available funds is too low and the agency may use photos with these applications as well.

After the grant committee has met the agency will contact you via mail as to the decision of the committee. Letters of approval or denial will be generated within one month of the meeting date. Unfortunately we are not always able to approve all requests. If a gift card is approved for clothes, household items or food the agency requires that the Medicaid Service Coordinator accompanies the family. All receipts must be submitted to the agency by the end of the quarter. Subsequent grants will not be considered if receipts have not been submitted.

Thank you for applying to our agency for a FSS grant. Please contact Toni Wakefield at (518) 372-2814 or twakefield@familyandchildservice.com with any questions or assistance needed in completing the application.

Office Use Only:

Category: _____

Last Name: _____

Family and Child Service of Schenectady, Inc.
246 Union Street Schenectady, NY 12305 (518) 372-2814
Fax: (518) 393-3601 or 372-2844

APPLICATION FOR FAMILY REIMBURSEMENT GRANT

Office Use Only:

Date of Application: _____
Application Completed By: _____

_____ #
_____ Qtr.
_____ Yr.

Name of Applicant: _____
Person with Disability
Address: _____
Street City State Zip Code
Phone Number: _____
Date of Birth: _____ Sex (circle one): Male / Female
Social Security Number: _____
Medicaid Number: _____ Tabs Number: _____

Persons Living in the Home (please list only the parent(s)/guardian(s) and children under 18):

Parent(s)/Guardian(s):

_____	_____	_____
Parent/Guardian (First, Last)	Home Phone	Work/Cell Phone
_____	_____	_____
Parent/Guardian (First, Last)	Home Phone	Work/Cell Phone

Children (**do not include applicant**) Under 18:

_____	_____	_____
Name	Relationship	Age
_____	_____	_____
Name	Relationship	Age
_____	_____	_____
Name	Relationship	Age
_____	_____	_____
Name	Relationship	Age
_____	_____	_____
Name	Relationship	Age
_____	_____	_____
Name	Relationship	Age

Medicaid Service Coordination Information:

Is the applicant currently enrolled in a Medicaid Waiver? Yes _____ No _____ Pending _____

Case Manager/Service Coordinator: _____ Phone: _____

E-Mail Address: _____

Agency Name: _____

Agency Address: _____
Street City State Zip Code

Please list all included services: _____

Please list any DSS Services received by applicant (food stamps, HUD, et cetera):

Please list any other Waiver and/or Respite services the applicant currently receives:

Service	Agency Name	Agency Phone #
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Disability Information:

1. Please indicate all disabilities by checking all that apply:

Mental Retardation _____ Cerebral Palsy _____ Epilepsy _____ Autism _____
Down Syndrome _____ Visually Impaired _____ Spina Bifida _____ TBI _____
Hearing Impaired _____ Other: _____

2. Any other medical concerns (shunts, pacemakers, et cetera):

3. Adaptive equipment already used (eye glasses, hearing aids, AFOs, et cetera):

Please indicate any major shift in the family dynamic within the past year that has caused undue hardship (i.e. loss of a job, hospitalization, death in the family, et cetera):

Other Grant Information:

1. Please list all grants that the applicant has received since the beginning of the current calendar year:

_____	_____	\$ _____	_____
Item(s) Received	Agency Name	Cost of Item	Date Received
_____	_____	\$ _____	_____
Item(s) Received	Agency Name	Cost of Item	Date Received
_____	_____	\$ _____	_____
Item(s) Received	Agency Name	Cost of Item	Date Received
_____	_____	\$ _____	_____
Item(s) Received	Agency Name	Cost of Item	Date Received

2. Is the applicant currently applying elsewhere with this same request? Yes _____ No _____

_____	_____	_____
Agency Name	Agency Phone #	Date Requested

3. Has the applicant applied to other agencies with this same request in the past and been denied?

Yes _____ No _____

_____	_____
Agency Name	Date

Reason for Denial	

Income Information:

1. Total Household Income per Year (including all sources of income): \$ _____

2. Sources of other income not including working wages (SSI, SSD, Child Support, et cetera):

(1) \$ _____ per year	Source _____
(2) \$ _____ per year	Source _____
(3) \$ _____ per year	Source _____

3. Do you: Own _____ Rent _____ Other _____

4. What additional expenses do you have related to your child's disability:

5. What health insurance do you/your family currently have? _____

Current Request:

*A minimum of three estimates is required for applicable items (furniture, adaptive equipment, appliances, etc.)

*A denial letter from Medicaid , private insurance or Waiver service is also required for any applicable items (adaptive equipment, environmental modification, medical procedures, etc.)

Request:	Amount Requested
_____	\$ _____
_____	\$ _____
_____	\$ _____

Justification for the requested item(s) (please attach an additional page if necessary):

Please complete this section only if you are requesting respite reimbursement. All of the following information is mandatory:

1. _____
Worker Name Worker Phone #
2. Does the applicant currently receive Waiver Respite or any other form of respite? Yes ___ No ___
_____ Agency Name Form of Respite Hours per Week
3. Does the applicant currently receive Residential Habilitation? Yes ___ No ___
_____ Agency Name Hours per Week
4. If the applicant is already receiving Respite or Residential Habilitation services please explain why it is necessary that he/she receive additional services:

Signatures required.

_____	_____
Applicant	Date
_____	_____
Advocate	Date
_____	_____
Service Coordinator	Date