Family Reimbursement Guidelines

Family Reimbursement programs are programs provided by AHRC that provide monetary assistance to people with developmental disabilities who live with their family in New York City. The programs are funded by OPWDD.

AHRC operates the following Family Reimbursement programs: The Francesca Nicosia Family Reimbursement Fund (all boroughs), Brooklyn Camp Scholarships, Brooklyn Emergency Reimbursement and Queens Emergency Respite Reimbursement.

The purpose of Family Reimbursement programs is to compensate families for expenses not reimbursed by other means, but which directly benefit the person with a disability. There are no age restrictions for the applicant, but they must qualify for services from OPWDD. The review committee will consider income, the nature of the request and the applicant’s award history when prioritizing applicants. The committee will meet approximately once per quarter (every 3 months) to review applications. Applications are reviewed in the order that they are received if they are complete. The fiscal year begins on July 1st of each year.

The request for funds should not be for an ongoing need, but rather an item or short-term service that will enhance the quality of life of the person with a disability, and can be for items not yet purchased. Some examples include camping costs, adaptive toys, educational devices, and special appliances or furniture required due to a specific need of the person with disabilities. Only one check, however, will be issued per award.
Family Reimbursement Program
Application Checklist

Applications will not be considered for review until the package is complete. Please make sure your package is complete when you send it in by including the following in your application package:

- A completed and signed 2019-2020 Fiscal Year application form
- Original receipt (s) or estimate for the item/service requested
  Receipts must have valid dates within the 2019-2020 fiscal year
  (i.e. all receipt(s) must be from July 1, 2019 to June 30, 2020)
- A completed and notarized AHRC Respite Form and Statement of Services Rendered (if the service requested is for respite care)
- Reimbursement request/justification

(ONLY ONE of the below documents are required)

- OPWDD eligibility determination letter
- Level of Care Determination (Current)
- MSC approval letter
- HCBS waiver notice of decision

Awards will not exceed: $500.00 for Nicosia Family Reimbursement
$1,000 for Brooklyn/Queens Emergency Reimbursement
$1,000 for Brooklyn Camp
Guidelines for Family Reimbursement *(Please note that eligibility does not guarantee approval)*

1. There must be a family member with a developmental disability. Single individuals with a disability living alone are not eligible.

2. Families receiving services from the foster care system are also not eligible.

3. The requested support must be appropriate for the person with a developmental disability.

4. The requested support should not be normally funded through other sources (Medicaid, insurance). For example, if you are applying for reimbursement for a medical bill, you must include a letter from the doctor stating that insurance/Medicaid did not pay for the service and why.

5. A person may be considered for reimbursement once every fiscal year.

**Application Process**

1. The application should be submitted complete and with all the required information. All original receipts or estimates need to be from **July 1, 2016 to June 30, 2017**.

2. Examples of some acceptable items for Family Reimbursement Applications

   * Summer Camp tuition
   * Respite
   * * Furniture, including bedding
   * * Clothing for a specific purpose or due to a specific need *(explain in the application)*
   * * Air Conditioner *(attach a justification letter with a doctor’s note)*

3. Examples of some acceptable items for Emergency Reimbursement:

   * Goods destroyed in fire (Emergency Reimbursement)
   * Respite expenses incurred to care for the person with a developmental disability when a family member is hospitalized (Emergency Reimbursement)
* Extermination fees and/or new bed (with proof of extermination) due to bed bugs

4. Examples of items that are usually not allowable:

* Taxes
* Fines
* Care provided by natural or adoptive parents of a minor child.
* Luxury items
* DVD Players, VCRs, Video Cameras
* Ongoing needs such as utility bills

5. If the request is for reimbursement for camp tuition for a waiver funded camp, the request must include a letter of attestation indicating the TABS program code, and number of hours not billable to Medicaid. If the camp receives Department of Education funding for students receiving IEP mandated 12 month education programming, information must be provided on the invoice indicating the actual or anticipated DOE funding.

6. Instructions for Respite Reimbursement

Please complete and notarize the Hourly Respite Services Form as proof of services rendered. The attached Hourly Respite Services Form must include the reason for service(s) provided, the amount service provider was paid and method of payment (cash, personal check, or money order). The Hourly Respite Services Form must include the following information: date(s) of service, time of service, rate per hour of service, amount paid, and method of payment. The Hourly Respite Services Form must be signed by the individual or representative of the individual and signed by the respite provider. The respite provider must also provide their address, phone number and social security number as well. The Hourly Respite Services Form must be submitted along with the application for consideration to receive funds. If all of the information for the statement of services rendered is not complete, your application will not be considered.

7. Purchased Items

If you have already purchased the item or service, please enclose the original receipt(s) with the application and list the name of the person to whom the reimbursement check should be written. Please provide a cancelled check, money order etc. to show that the purchase was an out of pocket expense.
8. Estimates

If you have not purchased the item, please enclose an estimate. The check will be written out to the store or provider. When acquiring the estimate, please remember to ask if the store will accept an AHRC check. Applicants or service providers may have to obtain the W-9 for companies that are not vendors within our system. We will let applicants know if the need to obtain this form is necessary and provide a reasonable amount of time for the form to be submitted.

9. Applications are reviewed by committee at least once a quarter. The fiscal year starts 7/1/2016.

10. The committee will first consider whether the person was awarded in the past year, the income of the family and the family size. Next, they will consider whether the items or services requested will enhance the quality of life of the person with a disability. The committee will also look at any special circumstances. Please thoroughly explain in the application or in a cover letter why the item or service is needed and how it will assist the person with a disability. Include any recommendations from doctors or therapists to support the application.

Our funding cycle starts on July 1st and ends when all funds are awarded; no later than June 30th. You will be notified in writing of the committee’s decision after your application has been reviewed. It is suggested that the application be submitted as early as possible in a given fiscal year. Unfortunately, funds are limited and may not be available to honor all applications.

Once complete, please send the application package to:

AHRC Family Reimbursement Programs
83 Maiden Lane 7th Floor
New York, NY 10038

For questions regarding the Family Reimbursement Programs, please contact: (917) 715-8035
or email: AHRCFamilyReimbursementPrograms@ahrcny.org

Thank you for your interest in our Family Reimbursement Programs.
AHRC FAMILY REIMBURSEMENT PROGRAMS

Please indicate which program you are applying to (please choose only 1):

Francesca Nicosia Family Reimbursement Program ___
Brooklyn Camp Scholarships ___
Brooklyn Emergency Respite Reimbursement ___
Queens Emergency Respite Reimbursement ___

Instructions: * All receipts must to be from July 1, 2019 to June 30, 2020. Please complete all blank spaces, and attach all needed documents*.

*Today’s Date: __________________

*Applicant (Person with Disability): __________________________ Date of Birth: _________

*Address: __________________________________________

*City: __________________________ *State: __________ *Zip Code: ______________

*Home Phone#: __________________________ Gender: __________________________

*Clothing size: ________________ *Shoe size: __________________________

*Medicaid#: __________________________ *Social Security#: __________________________

Tabs ID# (if known): ________________

*Developmental Disability Diagnosis: __________________________
(Please attach documentation of OPWDD eligibility, for example Eligibility Determination letter, NOD, LOC, CR4)

*Name of Person Completing This Form: __________________________

*Relationship to applicant: __________________________ *Work Phone#: __________________________

Address (If different from above): __________________________________________

If a parent/family member, please provide email address: __________________________

If a Care Manager/Service Coordinator, please indicate the name of the organization:
*Please describe the goods and/or services that were or will be purchased. If you are requesting funding for an item or service, describe what you would like to purchase or the service that was provided. Please be specific:

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

**Justification**

Describe how the goods and/or services purchased directly benefited the applicant. If you have not made the purchase, describe how the goods and/or services would benefit the applicant. If the service is therapeutic, please attach a letter from a doctor or other clinician explaining the benefit of the service. Letters must include name, signature and license #. If the request is for a bed or mattress larger than twin size, please attach letter from a Dr explaining why this is necessary.

____________________________________________________________________________________
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____________________________________________________________________________________
Have you requested that these services be paid for or provided by Medicaid or any other government funding sources?  [ ] Yes  [ ] No

* If yes, what was the outcome?

_________________________________________________________________________

_________________________________________________________________________

Have you applied for these goods and/or services from other family reimbursement providers?  [ ] Yes  [ ] No

If yes, please give the name of the agency, date of application and your current status:

_________________________________________________________________________

_________________________________________________________________________

Complete the income scale below for the applicant's household:

Total Family Income (including benefits or entitlements e.g. SSI, PA, etc.):

Income Amount: __________________________

Number of adults in household: _____________

Number of children in household: ____________

Please describe any unique circumstances or special expenses that impact your financial situation as it relates to this application:

_________________________________________________________________________

_________________________________________________________________________
What is the total dollar amount of these goods and/or services? $__________ *(Please attach original receipts/estimates or other supporting documents.)

**If the goods and/or services have been paid for, please write the name and address of the person to receive reimbursement. (This is usually the care giver of the applicant.)**

**If it is an estimate, the name and address of the store or service to receive the payment:**
Name: ___________________________________________________________________
Address: ___________________________________________________________________
Number: ___________________________________________________________________

If an estimate is submitted and approved, the check will be made out to the store or vendor and mailed to the applicant/family member. Camp estimates if approved, will be sent directly to the camp and the applicant/family member will be notified.

Person Completing the Application: __________________________________________

Signature of Person Completing the Application: _______________________________

For Office Use only (Staff signature): _______________________________________

Date Received: _______________ Date Reviewed: _______________

Approved: __________________

Comments/follow-up needed: ______________________________________________

Program: _______________________________________________________________
AHRC New York City’s Nicosia Family Reimbursement Program
Hourly Respite Services Form

Applicant (Person with Disability):

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<th>Date of Service</th>
<th>Time of Service</th>
<th>Rate Per Hour</th>
<th>Total Hours of Service</th>
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Statement of Services Rendered (The below information must be completed in its entirety.)

Reason for Service: ____________________________________________________________

Amount Paid to Provider: $ ____________________________

Method of Payment Received by Provider: ____________________________

I, the undersigned, verify that I was paid the above stated amount for providing respite service(s) for:

(Full Name) __________________________________________ (Last Name) __________________________________________

Provider Name (please print):

(Full Name) __________________________________________ (Last Name) __________________________________________

Provider Signature: ____________________________

Provider Address: __________________________________________

Provider Phone Number: ____________________________

Social Security Number: ____________________________ Date: _______ / _______ / _______

Notary Public: ____________________________ Date: _______ / _______ / _______

Please do not notarize if the statement of services rendered is incomplete.