The Arc, Oneida-Lewis Chapter, NYSARC

Family Support Services

Respite Reimbursement Request Form

New to Arc____ Receiving Arc Services _____

On-Going Request____ One Time Only Request_____ Annual Recertification _____

Name of Applicant:_____

Name of Caregiver/Payee:_____

Date of Birth:____/____/____ Tabs ID Number: _____ Social Security #:____-____-____

Is applicant eligible for Medicaid? Yes: **Medicaid #**_____ No: **(Attach denial letter)**

Address of Applicant: _____

City: _____ County: _____New York Zip Code: _____

Telephone Number:_____ Cell Phone Number:_____

Family's Email Address:_____

Need for Respite **(circle one):**

a) Over 12 years of age and the family needs respite due to the inability of the person to stay home alone.

b) Under 12 years of age and the family is unable to obtain a respite caregiver due to the extent of the developmental disability.

c) If "b" is checked, please complete at least one of the following for needs beyond what is considered to be typical for the person's age.

i) Please describe personal care needs:

ii) Please describe behavioral concerns:

iii) Please describe medical needs:

Please describe efforts to obtain caregiver and options attempted:

Amount of Quarterly Request:_____. ISPM Score: _____.

Additional circumstances which can be considered **(check all which apply):**

_____ Single parent/caregiver

_____ Non-parent primary caregiver (ex. Sibling, grandparent, aunt, etc)

_____ Age/medical condition of parent/caregiver

_____ Other people residing at home with developmental disabilities

Please list all Medicaid Waiver services the applicant currently receives (in-home or out-of-home) along with the provider agency.

Requests for Increases – In the event of an emergency, one-time increases outside of the family's category will be considered. Please indicate current allocation, amount of new request, and rationale for increase:

REQUIRED:

Parent/Caregiver Signature:_____Date:_____

Service Coordinator Signature:_____ Date:_____

Service Coordination Agency:_____ Telephone #:_____

ATTACH FOR NEW APPLICANTS ONLY:

- *** DDP2**
- *** DOCUMENTATION OF DISABILITY**
- *** COPY OF CURRENT ISP (If receiving MSC or the Waiver)**
- *** COPY OF MEDICAID CARD (If receiving Medicaid)**