

YAI Family Reimbursement Program Guidelines
PLEASE READ BEFORE COMPLETING APPLICATION

YAI's Family Reimbursement Fund provides financial assistance to people with developmental disabilities who reside at home with their family in **Brooklyn, Manhattan or Queens**. Applicants must have eligibility through the New York State Office for People with Developmental Disabilities (OPWDD).

Family Reimbursement compensates families for expenses that are not reimbursed or obtained through other sources. Families can be reimbursed for items or short-term services that enhance the person with a developmental disability's quality of life.

All applications are reviewed by a parent committee. When making a reimbursement determination, the committee will take into account the family's income, number of people in the household, how the items or services will enhance the quality of life for the person with a disability, family reimbursement award history, and any special circumstances that may exist. Applicants will be notified in writing of the committee's decision. Applications are reviewed quarterly (every 3 months).

YAI's Family Reimbursement funding cycle begins on July 1st of each year and ends when all funds are awarded; no later than June 30th. Brooklyn families can apply for Camp Family Reimbursement every other year.

APPLICATIONS MUST INCLUDE THE FOLLOWING:

Psychological Evaluation – A **complete Psychological report**, including an IQ score and an adaptive behavior score (within the last 3 years) **an update alone is not acceptable** and/or a Level of Care (LOC) (within 1 year) *(not required for Manhattan)*

Receipts or Estimates (dated July 1, 2019 - June 30th, 2020)

Receipts - If you have already purchased the item or service, provide original itemized receipts. Online receipts must reflect the order date and method of payment (GIFT CARD PAYMENTS ARE NOT ACCEPTABLE).

Estimates - If you have not yet purchased the item, provide an estimate. If awarded, the reimbursement check will be written out to the store or provider. When acquiring the estimate, confirm that the store will accept a YAI check also please provide a W-9 from the store.

Justification Letter (if applicable)

Any therapeutic item or clinically-based service that is not covered by insurance will need supporting documentation outlining the clinical reason for the item or service. The documentation must be from a licensed professional, explaining why the item is necessary and how it would benefit the person with I/DD. **The documentation must be on letterhead, original and include the professional license number, signed and dated. (COPIES ARE NOT ACCEPTABLE).**

Respite Timesheet (if applicable)

The family must complete YAI's hourly respite timesheet to document respite care. The form must be notarized and signed by the family member and respite provider. **Cancelled check or money order must be provided as payment for the respite services. (CASH PAYMENTS ARE NOT ACCEPTABLE). If you have not paid the respite provider, the reimbursement check will be written out in the provider's name. A W-9 from the respite provider must also be included.**

Confirmation Letter of Camp Attendance (Brooklyn and Queens Residents)

ITEM SPECIFIC GUIDELINES:

These are overall guidelines to follow for specific items/services; this is not an all inclusive list and any additional items/services can be considered by the agency on a case by case basis.

Air Conditioners - Applications must include a justification letter from a medical doctor.

Recreation – For recreation activities the invoice must include a breakdown of the number of sessions and the number of hours per sessions (i.e. how many sessions, how long are the sessions, amount per session and staffing ratio. **Must also include a justification letter from the Occupational Therapist (OT) or a Physical Therapist (PT).**

Bed Bug Infestation - Applications must include documentation that the landlord is not responsible for the bedbug treatment. Also, applications must include the original bill from a licensed exterminator showing treatment was done and a later inspection to show that the home is bedbug free.

Camp Funding - Manhattan residents must first apply for camp funding through SCO, NYS Institute on Disability and QSAC. Brooklyn and Queens residents must provide a confirmation letter of camp attendance.

Clothing - Applications must indicate the need of clothing for a specific purpose or due to a specific need. Must include clothing and shoe size.

Medical & Adaptive Equipment - Applications must be accompanied by documentation from a licensed professional explaining the person's need for the item. Manhattan residents must apply to ADAPT first and provide denial documentation before applying to YAI.

Support Services - Applications for support services, such as respite, will only be considered when there are unusual circumstances as other programs may be able to meet a families respite needs.

Family Reimbursement will typically not cover the following: computers/computer software, electronic devices, music players, taxes, fines, care provided by natural or adoptive parents to a minor child, ongoing needs such as utility bills.

**Submit your application to:
YAI
Family Reimbursement Program
220 East 42nd Street, 8th Floor
New York, NY 10017**

If you have any questions regarding the review process, or if you have not received a response within three months of when you submitted your application, contact YAI's Family Reimbursement Program at 212.273.6585.

Family Reimbursement Application
 Aplicación de Reembolso para las Familias

Applicant's Name (person with I/DD)

Nombre del aplicante (persona con I/DD)

Date of Birth

de nacimiento

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Social Security Number

Número de seguro social

Medicaid Number (if applicable)

Número de Medicaid

TABS ID Number

Número de TABS

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Applicant Clothing Size (i.e. S/M/L, XL 0, 2, and up)

Talla de ropa del aplicante

Applicant Shoe Size

Número de zapatos del aplicante

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Address

Dirección

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Primary Phone Number

Número de teléfono primario

Secondary Phone Number

Número de teléfono secundario

Email Address

Dirección de correo electrónico

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Applicant's Parent/Caregiver

Nombre del padres/ cuidador

Relationship to Applicant

Relación con el aplicante

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Developmental Disability (check all that apply)

Discapacidades del Desarrollo (marque todos los que apliquen)

<input type="checkbox"/> Intellectual Disability <input type="checkbox"/> Autism <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Down Syndrome <input type="checkbox"/> Neurological Impairment Discapacidad Intelectual Autismo Parálisis Cerebral Síndrome de Down Impedimento Neurológico
<input type="checkbox"/> Epilepsy <input type="checkbox"/> Traumatic Brain Injury <input type="checkbox"/> Other (specify) _____ Epilepsia Lesión cerebral traumática Otro (especificar)

Name of Person Completing Application

Nombre de la persona que completa la solicitud

Agency (if applicable)

Agencia (si corresponde)

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Address of Person Completing Application

Dirección de la persona que completa la solicitud

Number

Número de teléfono

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PLEASE NOTE: INCOMPLETE APPLICATIONS WILL BE RETURNED
 Por favor tenga cuenta que se devolverán las solicitudes incompletas

What is the item(s) or service requested for reimbursement? Describe item(s)

Especifique los artículos comprados o el servicio requerido

Describe how the item or service will enhance the applicant's quality of life

Describe cómo el artículo o servicio mejorará la calidad de vida del solicitante

Amount being requested for reimbursement

Costo requerido

\$

List other reimbursement agencies applied to for this particular item/service: **Not Applicable**

Indique a que otras agencias de reembolso ha solicitado este artículo/servicio

no aplica

Agency: Agencia	Date: Fecha	Funds approved? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending Fondos aprobados Si No pendiente If Yes, amount received: \$ Si es así, monto recibido:\$
Agency: Agencia	Date: Fecha	Funds approved? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending Fondos aprobados Si No pendiente If Yes, amount received: \$ Si es así, monto recibido:\$
Agency: Agencia	Date: Fecha	Funds approved? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending Fondos aprobados Si No pendiente If Yes, amount received: \$ Si es así, monto recibido:\$

Signature of Applicant or Parent/Caregiver

Firma del aplicante

Date of Application

Fecha de la aplicación

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Family Reimbursement Income
Ingresos familiares - Reembolso para las Familias

Name of Person with I/DD

Nombre de persona con I/DD

Name of Parent/Caregiver

Nombre del cuidador

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Number of Adults in the Household

Número de adultos en la casa

Number of Children in the Household

Número de niños en la casa

Total Family Income

\$

*Include any benefits (SSI, Public Assistance, Social Security, Child Support)

Incluya todos los beneficios (SSI, Asistencia Pública, Seguro Social, Manutención para niños)

Please explain any unique circumstances or special expenses that have an impact on your financial situation

Por favor escriba las circunstancias únicas o especial que impacta su financiera situación

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Family Reimbursement Respite Hourly Timesheet

Respite - Reembolso para las Familias

One timesheet per respite provider.

Solamente una planilla de horario por proveedor de servicios

Respite Provider's Name

Nombre de trabajador

Respite Provider's Social Security Number

Número de seguro social del trabajador

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Date of Service <small>Día del Servicio</small>	Day of the Week <small>Día de la semana</small>	Hours of Work <small>Horas trabajadas</small>	Total Hours of Work <small>Total de horas</small>	Hourly Rate <small>Tarifa por hora</small>	Payment Method <small>Metodo de pago</small>
7/5/2017	Wednesday	7pm - 5pm	2 hrs	\$11.00	check
Total Hours:					

Total Paid:	\$
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Parent/Caregiver's Signature _____ Date _____

Respite Worker's Signature _____ Date _____

NOTARY

STATE OF NEW YORK

COUNTY OF _____

On the _____ day of _____ in the year _____ before me, the above signed, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to this application and acknowledged to me that he/she executed the application and swore that the statements made by him/her in the application and all supporting materials are true, complete, and correct.

Notary Public signature _____

Notary ID number _____

Expiration date _____ / _____ / _____
Month Day Year

NOTARY STAMP

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