YAI Seeing beyond disability.

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 Life Plan (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.**

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 family's 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.

YAI Seeing beyond disability.
220 East 42nd Street, 8th Floor
New York, NY 10017
Tel. 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

Social Security Number
Número de seguro social

Medicaid Number (if applicable)
Número de Medicaid

TABS ID Number
Número de TABS

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

Address
Dirección

Primary Phone Number
Número de teléfono primario

Secondary Phone Number
Número de teléfono secundario

Email Address
Dirección de correo electrónico

Applicant's Parent/Caregiver
Nombre del padres/ cuidador

Relationship to Applicant
Relación con el aplicante

Developmental Disability (check all that apply)
Discapacidades del Desarrollo (marque todos los que apliquen)

☐ Intellectual Disability (Discapacidad Intelectual) ☐ Autism (Autismo) ☐ Cerebral Palsy (Parálisis Cerebral) ☐ Down Syndrome (Síndrome de Down) ☐ Neurological Impairment (Impedimento Neurológico)

☐ Epilepsy (Epilepsia) ☐ Traumatic Brain Injury (Lesión cerebral traumática) ☐ Other (specify) (Otro (especificar)) _____

Name of Person Completing Application
Nombre de la persona que completa la solicitud

Agency (if applicable)
Agencia (si corresponde)

Address of Person Completing Application
Dirección de la persona que completa la solicitud

Number
Número de teléfono

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

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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
Describa 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** no aplica
Indique a que otras agencias de reembolso ha solicitado este artículo/servicio

Agency: Agencia	Date: Fecha	Funds approved? ☐Yes ☐No ☐Pending Fondos aprobados Si No pendiente If Yes, amount received: $ Si es así, monto recibido:$
Agency: Agencia	Date: Fecha	Funds approved? ☐Yes ☐No ☐ Pending Fondos aprobados Si No pendiente If Yes, amount received: $ Si es así, monto recibido:$
Agency: Agencia	Date: Fecha	Funds approved? ☐Yes ☐No ☐ 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

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

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

Total Paid:	**$**

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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