UNITED CEREBRAL PALSY OF NEW YORK CITY, INC.
110 ELMWOOD AVENUE BROOKLYN, NY 11230
718-859-5420 EXT 244
DANIELLE RAYMOND
FAMILY OUTREACH COORDINATOR
FAMILY REIMBURSEMENT FUND

APPLICATION FOR GOODS AND / OR SERVICES

ALL APPLICATIONS THAT ARE NOT COMPLETE WILL BE RETURNED

THIS APPLICATION IS FOR MANHATTAN RESIDENTS ONLY

AWARDS ARE NOT GUARANTEED

The approval process can take 3 to 6 months

Eligibility for UCP of NYC Family Reimbursement

There must be a family member with a developmental disability and the individual must be living with a family member.

According to OPWDD Family Support Services guidelines, it is imperative that all applications contain documentation of a developmental disability.

The merchandise or service requested must only be for the benefit of the person who has a developmental disability.

FISCAL YEAR:
STARTS July 1 and ends June 30. All receipts must be dated within the current fiscal year, and must be clear and legible. The application and any estimates for goods or services must also be dated within the fiscal year.

ALL APPLICATIONS MUST INCLUDE A DETAILED STATEMENT OF NEED. Please be sure to sign and date. (Why this family should be reimbursed)

CAMP FUNDING:

Manhattan residents must apply for camp funding through other agencies. We do NOT provide camp reimbursement for Manhattan residents.

RESPITE:
The family must use UCP of NYC's respite form to document respite care. The form MUST be notarized and signed by the family member and the caregiver. The caregiver must also provide their address.

UTILITY PAYMENTS:
The family must provide the original current bill as well as a letter from the MSC with justification for no-payment. Bill must indicate **"Final notice or shut-off notice".**

BED BUG INFESTATION:
The family must provide the original bill from a licensed exterminator showing treatment was done and a later inspection to show that the home is bed bug free.

RECEIPTS:
We can only accept original itemized receipts**. We cannot accept generic or handwritten receipts for items**. The receipts must be dated within the current fiscal year.

THERAPUTIC ITEMS:
If the request is for a therapeutic item, clinical documentation from a licensed professional explaining why the item is necessary and how it would benefit the individual with the disability, must be included. The documentation must include the physicians stamp and license number and must be the original. We **do not** accept photocopies.

MEDICAL AND ADAPTIVE EQUIPMENT:
If the request is for medical or adaptive equipment, medical documentation supporting a need for the equipment must be included. You must also show proof that Medicaid or your medical insurance does not cover the item.

AIR CONDITIONERS
Items such as bed, dressers, and air conditioners must be paid for by the family. All requests for air conditioners must be accompanied with an original doctor's justification.

We cannot reimburse for food.

UNITED CEREBRAL PALSY OF NYC
110 Elmwood Avenue Brooklyn, NY 11230
FAMILY REIMBURSEMENT APPLICATION
Awards are not guaranteed, and are contingent on the availability of funds.
Awards are distributed quarterly

INCOMPLETE APPLICATIONS WILL BE RETURNED

Please answer all questions **Please print**

CONSUMER INFORMATION

Date:_____

Name of Person with Disability:_____
TABS #_____
Current Address:_____City_____
Zip Code_____
Phone #:_____ Date of Birth:_____
SS#_____ Medicaid #_____
If the disabled individual receives services from an agency please list:
Name of Agency:_____ Phone #_____
Name of Program Contact Person:_____
Services Received:_____
Telephone # of Case Manager_____
Which developmental disability does the person have _____

PURCHASE INFORMATION

If purchase has already been made, original receipt MUST be attached.
All of the questions in this section **must be answered.**
What item(s), service(s) do you want reimbursement for? Please specify:_____
What is the total cost? $_____How much can you contribute? $_____
What amount are you asking to be reimbursed for? $_____
Specify all other ways of paying for item(s) and/or service(s) you have tried, before making this request:
Please name all traditional means attempted as per attached page and affix all supporting documents.

_____

What were the results of your efforts?_____

If your application is approved, the check will be made out to the person or vendor. List name of person or vendor:

_____

APPLICATIONS NOT COMPLETELY FILLED OUT WILL BE RETURNED

The approval process can take 3 to 6 months

FAMILY INFORMATION

Name of Parent/Guardian:_____
Relationship to Individual _____Number of Members in Household_____
Number of family members employed:_____

Where do you reside? Home_____ Residence_____ Foster Care:_____

Total Family Income: $1-$24,999.00( ) $25,000- $49,000( ) $50,000-$74,999( ) $75,000-$99,000( ) $100,000 and over( )_

Do you have health insurance coverage:_____

OTHER INFORMATION

Have you received any type of reimbursement within the last year: Yes [ ] No [ ] If yes, please specify: Agency_____Amount $_____Purpose_____Date rec'd_____

Have you/are you going to apply to other agencies for reimbursement for this request?

Yes ( ) No ( )

If yes, please specify:Agency:_____When and/or date of application:_____
As of this date, have any of these agencies committed to partial or full reimbursement of this request?
Yes ( ) No ( ) If yes, please specify:Agency:_____Amount: _____
If your application is approved, the check will be made out to the person or vendor. List name of person or vendor:_____

I have attached my original receipts and supporting documents where necessary.

PERSON FILLING OUT APPLICATION TO COMPLETE THE FOLLOWING.

Name: _____Signature_____

Address:_____

Phone Number:_____Relatationship to Indiviual_____

UNITED CEREBRAL PALSY OF NEW YORK CITY, INC.

STATEMENT OF NEED:

WHY IS THIS GOOD/SERVICE NEEDED? PLEASE BE SURE TO EXPLAIN ANY SPECIAL CIRCUMSTANCES THAT EFFECT YOUR FAMILY'S FINANCIAL SITUATION.

THIS FORM MUST BE FILLED OUT FOR ALL REQUESTS

UNITED CEREBRAL PALSY OF NEW YORK CITY, INC.

Family Reimbursement Program-Claim Form for Hourly Respite Services

If you are requesting reimbursement for hourly respite services please send use this form and submit with the following:

1) A detailed written explanation why you needed help
2) Proof of payment such as a cancelled check or money order stub
3) **This form must be signed by the parent or guardian and the respite worker and must be notarized.**

Complete this form following the given example below:

Date	Day of the Week	Hours of Work	Total Hours	Hourly Rate	Workers Name Print	Caregiver's Signature
1/1/01	*Monday*	*4*	*4*	*11.50*	*Jane Doe*	*In Blue Ink*

*** Maximum is $10.00 per hour**

I verify that the above listed services were received

Caregiver's Signature **Parent or Guardian's Signature**

Address of Caregiver

Notary Information:

Please return completed application to:

Danielle Raymond
Family Outreach Coordinator
110 Elmwood Avenue,
Brooklyn, New York, 11230