UCP United Cerebral Palsy of Suffolk

Thank you for your interest in our Family Voucher Reimbursement/In home Respite programs. In order to process your request, the attached paperwork must be **fully completed**. The documents should be printed up, completed and returned. If returning by email, please send to aschein@ucp-suffolk.org.

Attached are the following documents which need completion:

1. *Application*- please ensure the application is fully completed, signed and dated. If not signed and dated, it cannot be processed.
2. *Family Support Services Guidelines-* Please keep for your records.
3. **For In Home Respite program only**:
   a. *Family Profile for voucher reimbursement*. Please note that the **Payee's social security number** is needed for tax purposes. If this is not in the profile, it cannot be processed.
   b. *Service Contract*

Please note the application requires a justification as to why the item requested is needed specific to your family member's developmental disability. Examples of this can be Camp for increasing socialization, Respite for caregiver relief or Swim classes for community integration. These are just examples. If you are having difficulty with this or any other part of the application, please feel free to reach out to me at 631 232-0011 Ext 415 or email me at aschein@ucp-suffolk.org.

We look forward to working with you!

Fiscal Year: **2021** Date of Request: _____

UNIVERSAL REIMBURSEMENT REQUEST

(In order to be processed please answer every question)

Applicant: _____ Date of Birth: _____ Age: _____

Applicant's sex: (Circle One) Male or Female Medicaid Number: _____ Tabs#: _____

Address: _____ City: _____ Zip Code: _____

Applicants Social Security #: *(only if TABS # is unknown)* _____ School/Day Program: _____

Parent/Guardian: _____ Phone #: _____

Parent/Guardian e-mail address: _____

Care Manager: name / phone / e-mail address: _____

Ethnicity: (For Demographic purposes only) ___African-American ___Asian/Pacific Islander ____Hispanic
___Native-American ___White ___Other

Have you applied to/been approved for reimbursement from any of the following agencies?
ACDs, Angela's House, Nassau AHRC, Citizens, Suffolk AHRC, East End Disability Associates, Inc., FREE, Head Injury Association, Greater 5 Towns JCC, LIFE, LIDDRO, SCO Family of Services, UCP Nassau & UCP Suffolk

Yes __ No __ If yes, what agency: _____ When: _____

Does applicant have private medical insurance? No___ Yes___

Check if the applicant is enrolled in and receiving funding/services from either of these programs:

HCBS Waiver _____ Care at Home _____ Self Direction _____

List all members of household:

Name	Age	Occupation	Health Status
_____	___	_____	_____
_____	___	_____	_____
_____	___	_____	_____
_____	___	_____	_____

Check your current household income:

Under $50,000 _____ $80,000-95,000 ____ $110,000-150,000 _____
$50,000-65,000 _____ $95,000-110,000 ____ Over $150,000 _____
$65,000-80,000 _____

Disabilities: Indicate "1" for primary (mark only one) and "2" for all other(s) that apply:

__ 1. Intellectual Disability
__ 2. Autism
__ 3. Cerebral Palsy
__ 4. Epilepsy/Seizure Disorder
__ 5. Other Neurological Impairment
__ 6. Psychiatric/Emotional Disability
__ 7. Chronic Physical/Med. Condition
__ 8. Sensory Impairment
__ 9. Traumatic Brain Injury
__10. Other _____

Reimbursement:

1. What specific service(s) or goods are you requesting funds for?
   (If requesting reimbursement for a service in which the school already provides, please send in a copy of the most recent IEP)

All Services / Items Requested	**Anticipated Cost**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please provide justification for how services / items needed are related to the individual's developmental disability:

_____

_____

2. Name of payee to be reimbursed: _____

3. What is the payee's Social Security Number: _____
   (**We cannot process without this number**)

By signing below, I am attesting that I have not or will not accept reimbursement from any other agency this fiscal year. I understand that doing so will jeopardize consideration for future funding.

"I have read and agree to adhere to the reimbursement guidelines."

_____ _____

Parent/Guardian Signature **Date**

Please note: A new application must be completed for each fiscal year.

For Office Use Only:

New or Renewal: _____ *Committee Meeting Date:* _____

	Date	Amount	
Approved:	_____	_____	FSS # _____
Denied	_____	_____	Pending: _____

FSS Staff Responsible _____

Revised 12/3/15

UCP United Cerebral Palsy of Long Island
Life without limits for people with disabilities™

FAMILY SUPPORT SERVICES REIMBURSEMENT PROGRAM

In-Home Respite & Family Voucher

GUIDELINES

PURPOSE

The Voucher Reimbursement Program is intended to assist the family caring for their family member with a developmental disability. The funds are designated to assist with increased expenses directly related to the disability and thereby enhance family stability and preserve family unity. Reimbursement is a 100% state funded program and is funding of last resort. It is not intended to cover goods and services covered through other funding sources ex: Medicaid, Self-Direction, HCBS Waiver, other insurances etc.

ELIGIBILITY

The following eligibility criteria must be met:

1. Individuals must have OPWDD eligibility.
2. Individuals must live at home with family (biological, adoptive or extended). Individuals living alone are not eligible to apply. Individuals living in foster care are also not eligible to apply.
3. Individuals enrolled in self-direction should explore if the item/service can be covered through the self-direction budget.
4. Individuals must reside in Suffolk county
5. Individuals must have completed the OPWDD Front Door assessment.
6. Individuals may not be receiving Reimbursement services from another agency.
7. In-Home Respite Reimbursement ONLY:
    a. Ages 3 to 21
    b. Cannot have HCBS Waiver

REIMBURSEMENT AMOUNTS & SUBMISSION DEADLINES

If eligible, each individual may receive reimbursement from UCP Suffolk's two reimbursement programs. These programs cannot be combined or overlap:

- Family Voucher Reimbursement -- for goods and services up to $1000
- In-Home Respite Voucher Reimbursement -- for in-home respite up to $1000
- Total combined reimbursement maximum is $2000 per individual.

Reimbursement is for expenses within the current calendar year (January 1st-December 31st). All receipts for the year must be submitted before the 5th business day of January of the following year. Any receipts submitted after this date will no longer be accepted. Families must re-apply for funds every year. Funding in one year does not mean you will automatically be approved for funding in the following year.

EXAMPLES OF ITEMS COVERED / NOT COVERED

The item being reimbursed must be related to the needs of the individual with a developmental disability. If this item or service will be shared by other family members, the reimbursement may be pro-rated based on the number of family members in the household. Specific guidelines for reimbursement of each item are established by OPWDD. Questions about covered or non-covered items can be addressed to the Program Supervisor.

Examples of non-covered items include:

Taxes, fines, shipping fees, the outright purchase of homes, vehicles, luxury items.

Example of covered items may include:

Adaptive Equipment/Durable Goods, Camp, Leisure, Recreation and Community Inclusion, Clothing, Crisis Situations, Dental treatment and sedation, Diapers/Pull-Ups/Wipes (not covered by Medicaid),

Eyeglasses/Hearing Aid Devices, Furniture, In-Home Respite, Medication and Doctor Co-pays, Nutritional Supplements & Diet items, Service Animals, Technology, Therapies, Transportation / Millage reimbursement

APPLICATION PROCESS

Applications will be reviewed and approved by an established process. The Program Supervisor will notify families in writing of the status of the application. Applications must be completed in full. Applications and respite verification forms must have original signatures. The application must indicate how the request is directly related to the individual's developmental disability. Depending on the reimbursement, additional documentation may be requested; for example, clinical justification, doctor's notes, or Explanation of Benefits (EOB) from your insurance company.

APPEAL PROCESS

In the event the application is denied and the family would like to appeal the decision, the family will be directed by the FSS Program Supervisor to contact the Director of Adult Services. The Director will review the family's request for a redetermination and communicate the decision to the family in writing.

REIMBURSEMENT PROCESS

- This is a reimbursement program. Families can submit an application to see if an item or service will be approved before they purchase the item; however, families are expected to pay for the item and then submit receipts for reimbursement.
- In some instances, the applicant may ask the Voucher Reimbursement provider agency to pay the vendor directly for the good(s) or service(s). In that case, the request must include justification with an explanation why the family cannot pay for the service or item first. Verification of the household income and the number of persons living in the home will be required.
- Reimbursement is made only after verifying that the receipts for goods and services are for items approved. If the family submits a receipt for reimbursement for an item that was not specifically approved, the request must be re-examined to ensure all criteria are met before payment can be processed.
- Original receipts must be submitted. Receipts must have the name of the vendor (store, recreation program, individual's name, etc.) and date. Hand written receipts must be signed and will be verified by the reimbursement agency. Do not highlight purchases on receipts as this may degrade what is written on the tape. Receipts should only be for the item(s) for which you are requesting reimbursement.
- Reimbursement payments will be sent within 30 days of submission to UCP's accounting department. If payment is not received, families should follow-up with Program Supervisor.

INTENDED USE

It is the expectation that the family/individual maintains the item in their possession and uses the item as originally intended in the application for the life of the item or an amount of time that is reasonable and appropriate. If the item is returned, sold, or is no longer in the family/individual's possession it is the family's responsibility to notify the agency that funded the item and make arrangements to reimburse the agency for the cost of that item as appropriate. If a claim for goods and services is discovered to be fraudulent an investigation will be conducted in cooperation with OPWDD and appropriate actions taken.

SATISFACTION SURVEYS

Every family will be provided an anonymous satisfaction survey upon completion of the reimbursement program for the calendar year.

For all questions related to the Reimbursement Program or to submit an application contact:

Arlene Schein
FSS Program Supervisor
UCP of Long Island
250 Marcus Boulevard
Hauppauge, NY 11788
Office: (631) 232 – 0011 extension 415
E-mail: aschein@ucp-suffolk.org

RESPITE PROGRAM

FAMILY PROFILE FOR VOUCHER REIMBURSEMENT

Date:_____

Payee Name:_____

Address:_____

_____

Child's Name:_____

Child's D.O.B._____

Payee's Name and Social Security Number:

_____

_____

Parent's Date of Birth: _____

Phone Number:_____

VOUCHER REIMBURSEMENT PROGRAM

SERVICE CONTRACT

CLIENT NAME:_____

1. You are responsible for screening, hiring, training and paying your respite worker.

2. The completed respite voucher form must be received by the respite coordinator at the above address on at least a monthly basis. THE VOUCHER BILLS MUST BE RECEIVED BY THE RESPITE COORDINTOR 7 DAYS AFTER THE LAST DAY OF EACH MONTH.

3. Respite Services will be reimbursed up to $1,000.00 per calendar year. You will be held responsible for any amount that exceeds the $1,000.00 limit.

4. At year's end, you will receive a 1099 miscellaneous income statement for all monies received.

5. I hereby hold completely free and harmless and fully indemnify, UCP, its Board, Officers, employees and agents from any and all liability, costs, damages, suits of any type or nature of any loss or damage resultant, either directly or indirectly, from any respite services received by me or family. I fully understand that UCP is responsible only for payment of certain respite vouchers and is not responsible in any manner for any of the services provided or the relationship between the respite worker and me, including non-responsibility for payments of any type to respite workers including wages, taxes, benefits or any other payments.

I, _____ agree to the utilization of the Voucher Reimbursement Program according to the above guidelines.

_____ _____

Parent/Guardian Date

_____

Parent Email address

_____ _____

Coordinator, Respite Program Date