

450 West Nyack Road, Suite 9, West Nyack, New York 10994  
Phone 845.627.0627 — Fax 845.627.0629 — Toll Free: 800.640.0371

www.learnaboutepilepsy.com  
www.capabilitiespartnership.com

**Working on behalf of people with epilepsy**

**APPLICATION FOR FAMILY EMPOWERMENT PROGRAM**

**I. FAMILY INFORMATION:**

Last Name \_\_\_\_\_ Consumer's First Name \_\_\_\_\_

Parent's Name (if child) \_\_\_\_\_ Phone (H) \_\_\_\_\_

(W) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Total Cost Requested: \_\_\_\_\_

**II. REQUESTED SERVICES:**

- |  |   |                                      |
|--|---|--------------------------------------|
| <input type="checkbox"/> Respite and Child Care    | <input type="checkbox"/> In-Home Assistance               | <input type="checkbox"/> Recreation  |
| <input type="checkbox"/> Environmental Adaptations | <input type="checkbox"/> Food                             | <input type="checkbox"/> Clothing    |
| <input type="checkbox"/> Rent Assistance           | <input type="checkbox"/> Utilities                        | <input type="checkbox"/> Insurance   |
| <input type="checkbox"/> Home Repairs              | <input type="checkbox"/> Physician Appointment            | <input type="checkbox"/> Medications |
| <input type="checkbox"/> Evaluation/Assessment     | <input type="checkbox"/> Transportation                   | <input type="checkbox"/> Nursing     |
| <input type="checkbox"/> Dental                    | <input type="checkbox"/> Counseling (other than epilepsy) |                                      |
| <input type="checkbox"/> Other                     | Specify _____   |                                      |

**III. DIAGNOSIS** \_\_\_\_\_

**IV. CHECK PAYABLE TO:**

Provider Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

V. Consumer/Family Intake on \_\_\_\_\_ By \_\_\_\_\_

VI. Consumer/Family request for \_\_\_\_\_ Consumer Contribution \_\_\_\_\_

VII. Reimbursement to be paid to \_\_\_\_\_ Consumer \_\_\_\_\_ Service Provider

VIII. Reimbursement for \_\_\_\_\_ one time payment only \_\_\_\_\_ monthly (less than 3 months)

\_\_\_\_\_ Monthly (3 to 6 months) \_\_\_\_\_ to be negotiated

IX. Receipts to be supplied \_\_\_\_\_ Yes \_\_\_\_\_ No

Receipts from: \_\_\_\_\_ For: \_\_\_\_\_

Receipts from: \_\_\_\_\_ For: \_\_\_\_\_

Receipts from: \_\_\_\_\_ For: \_\_\_\_\_



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X. Consumer agrees to: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

XI. Recipient has reviewed this agreement and terms stipulated to contract.

<b>Witness</b>	<b>Date</b>	<b>Consumer</b>	<b>Date</b>

XII. Any needed calculations for budget assessment should be in the space on the right.

XIII. Your contact person is: \_\_\_\_\_ Phone: \_\_\_\_\_

XIV. Check # \_\_\_\_\_ Date \_\_\_\_\_ Amount \_\_\_\_\_

Payee \_\_\_\_\_ Purpose \_\_\_\_\_

<b>Supervisor's Signature</b>	<b>Date</b>



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### FAMILY EMPOWERMENT FUND REQUEST

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Service Coordinator: \_\_\_\_\_ Agency: \_\_\_\_\_

Amount Requested: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Seizure Frequency: \_\_\_\_\_

Date of Diagnosis: \_\_\_\_\_ Secondary Diagnosis: \_\_\_\_\_

Neurologist or  
Physician: \_\_\_\_\_

Other: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Medications: \_\_\_\_\_ mgs. \_\_\_\_\_ Daily \_\_\_\_\_

\_\_\_\_\_ mgs. \_\_\_\_\_ Daily \_\_\_\_\_

\_\_\_\_\_ mgs. \_\_\_\_\_ Daily \_\_\_\_\_

\_\_\_\_\_ mgs. \_\_\_\_\_ Daily \_\_\_\_\_

Medical Coverage: \_\_\_\_\_ Medicaid \_\_\_\_\_

Medicare \_\_\_\_\_

Service Requested: \_\_\_\_\_ Provider: \_\_\_\_\_

Payee: \_\_\_\_\_

Justification:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



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**FAMILY EMPOWERMENT FUND REQUEST**

Income \_\_\_\_\_ Employed \_\_\_\_\_ Unemployed \_\_\_\_\_

Family Size: \_\_\_\_\_

Referred to EFSNY Employment Program? \_\_\_\_\_ Yes \_\_\_\_\_ No

If no, state reason: \_\_\_\_\_

How much do you receive monthly?:

SSI \_\_\_\_\_ SSD \_\_\_\_\_ PA \_\_\_\_\_ Other \_\_\_\_\_

Expenses:

Rent: \_\_\_\_\_ Utilities (Gas and electric): \_\_\_\_\_

Phone: \_\_\_\_\_ Car \_\_\_\_\_

Food: \_\_\_\_\_ Other: \_\_\_\_\_

TOTAL INCOME: \_\_\_\_\_

TOTAL EXPENSES: \_\_\_\_\_

**TOTAL:** \_\_\_\_\_

Do you have a savings account? \_\_\_\_\_ Yes \_\_\_\_\_ No

If so, how much? \_\_\_\_\_

Budgeting Plan? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, describe plan: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

Is consumer compliant with the above plan? \_\_\_\_\_ Yes \_\_\_\_\_ No

Other resources explored: \_\_\_\_\_

\_\_\_\_\_

Additional Comments: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

# Epilepsy Society of Southern NY's Family Empowerment Fund Policy

## Purpose:

ESSNY has been granted this fund in order to provide families in need with temporary financial assistance.

## Eligibility:

The individual for whom the request is made must have a developmental disability. At the time the application is submitted, we require that the documentation of the developmental disability be included as well. If the nature of the request warrants immediate payment we expect that the family will provide documentation within 7 business days of the approval of the request.

## Nature of the Requests:

It is our policy to reserve and prioritize these monies for emergency requests. The following are considered to be emergencies but not limited to: financial assistance to obtain medications, financial assistance to prevent eviction, financial assistance for a utility bill, financial assistance to purchase food, baby formula etc. These are examples of how ESSNY chooses to disperse the funds accordingly.

Please note, however, that ESSNY does consider additional requests and will do our best to meet each individual's needs based on the monies in the fund.

## Application Process:

In order to be considered for this fund, you must first complete the attached application. In addition, we ask you to provide the agency with a narrative that further substantiates your request. If the individual for whom the request is being made has an ISP, please submit that document with the application as well.

## Payment Policy:

If your request has been approved, ESSNY will pay the bill directly. Please be aware that ESSNY will not submit payment to an individual. For example: If the request is for medications, ESSNY will pay the pharmacy not the individual making the request. Therefore, in order to process payments accurately, ESSNY requires copies of the bill, pharmacy numbers etc. In rare situations, we will consider sending the check to an individual if we receive sufficient proof that the individual made the payment.

\* The Epilepsy Society of Southern NY reserves the right to change or adjust this policy as we see fit.