«DateReviewed»

«VendorName»

«VAddress»

«VCity», «VState» «VZip»

Re: «FirstName» «LastName» DDS # «DDSNum»

Dear «VendorName»:

The Individual and Family Grant that you applied for has been approved in the amount of: **$«AmtApproved»** for the purpose of: **«DetailedRequest»**. If you are still interested in accepting this Individual and Family Grant, please sign and date **Attachment A –Individual and Family Grant Agreement and Authorization** to acknowledge that you are in agreement with the terms and conditions of the grant and either send it to: DDS Individual and Family Grant Program at 25 Creamery Road, Cheshire, CT 06410, fax it to (860) 622-2657, or

e-mail it to DDS.WR.Individual-FamilyGrants@ct.gov.

After receiving the Individual and Family Grant you will be required to submit documentation accounting for how the grant funds have been used for the approved item or service. This documentation may include copies of receipts, copies of cancelled checks showing it was endorsed, or the DDS Individual and Family Grant Provider Payment Log which is a record of the hours and rate of pay of the person(s) providing supports. **Please do not send originals.** Please sign and date **Attachment B-Individual and Family Grant Expenditure Report** and submit with this documentation after the funds have been used. **Funds must be used by 6/30/YYYY.**

Additional Individual and Family Grants will not be considered for an individual until the DDS Individual and Family Grant Program has received proper documentation that the funds approved through this letter were used for the purpose specified above. Unused grant funds or grant funds used for another purpose without the department’s permission must be returned to DDS before another grant can be considered.

If you have any questions regarding this grant, please feel free to contact Jean Stack at (203) 806-8750.

Sincerely,

Jean M. Stack, MSW

Jean Stack, MSW

Individual and Family Grants Manager

Department of Developmental Services

25 Creamery Road
Cheshire, CT 06410

(203) 806-8750

CC: **«CM\_FirstName» «CM\_LastName»**

**ATTACHMENT A**

**Department of Developmental Services**

**Individual and Family Grant Agreement and Authorization**

**FYYYYY (July 1, YYYY to June 30, YYYY)**

|  |  |
| --- | --- |
| **Individual’s Name** | «FirstName» «LastName» |
| **DDS #** | «DDSNum» |
| **Grant Request Date** | «DateReq» |
| **Amount Approved** | $«AmtApproved» |
| **Item or Service Approved** | «DetailedRequest» |
| **Case Manager** | «CM\_FirstName» «CM\_LastName» |
| **Payee:** **«VendorName»** with Social Security # **«VendorUnique»** *If this is not your (the payee’s) correct Social security number or name listed above, please attach a copy of your Social security card to this form* |
| **Grant Information** | **Individual and Family Grant funds must be used for the specific Item or Service Approved as shown above. All expenditures must be made between <<DateReq>> and June 30, YYYY.**Any change to the approved use of the grant funds MUST be submitted to the DDS Individual and Family Grant Manager for review and approval BEFORE any change in the use of funding occurs. If funds are spent prior to the approval for a change, you will be responsible for paying those funds back to DDS.Any special equipment, furnishings, or items purchased under this agreement are the property of the individual and shall be transferred to his or her new residence or program at such time as the individual moves or changes his or her employment opportunity or day services program. |
| **Requirements for Expenditure Reporting** | When paying staff for Respite, Personal Support, or Individualized Home Supports, a DDS Individual & Family Provider Payment Log must be used. ***Cancelled checks will no longer be accepted.*** Please write in the date staff worked, number of hours worked, rate of pay, and the total paid for each date. Persons providing the services MUST SIGN each line stating that they have received the payment for their services.For any other purchases, you must submit copies of receipts, cancelled checks, or paid invoices for those items or services purchased along with the Expenditure Report, once all grant funding has been exhausted, but not later than September 30, YYYY. Failure to turn in documentation of how the grant funds were spent may result in an individual not being eligible for future Individual and Family Grants. If Individual and Family Grant funds are not used as intended, or not used at all, grant funds are required to be repaid to the State of Connecticut by the payee. |
| **Other:** | **All unspent grant funds must be returned in a check or money order made payable to: Treasurer, State of Connecticut. Please send these to the attention of:****DDS Individual and Family Grant Program, 25 Creamery Road, Cheshire, CT 06410**.You must keep original receipts, cancelled checks, or DDS Individual and Family Grant Provider Payment Log, if applicable, for three (3) years after receipt of the grant.It is your responsibility to ensure that workers supporting the individual are properly trained to protect the health and safety of the individual, you and your family members.  |

**By signing below, I confirm that I have read the agreement, and understand that these grant funds shall be used specifically for <<DetailedRequest>>.**

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

 Signature Date

**To expedite payment, please fax signed and dated agreement to the DDS West Region’s confidential**

**fax number: (860) 622-2657 or e-mail it to** **DDS.WR.Individual-FamilyGrants@ct.gov**

**Please return your Agreement by «RetnAgmtDate»**

**ATTACHMENT B**

**Department of Developmental Services**

**Individual and Family Grant Program Expenditure Report**

**FYYYYY (July 1, YYYY to June 30, YYYY)**

**«VendorName»**

**«VAddress»**

**«VCity», «VState» «VZip»**

**An Individual and Family Grant** for **«FirstName» «LastName» DDS # «DDSNum»**

in the amount of **$«AmtApproved»** for **«DetailedRequest».**

**IMPORTANT: FUNDING MUST BE USED BETWEEN <<DATEREQ>> AND 6/30/YYYY.**

* You (the payee) must return this signed Expenditure Report and copies of receipts, cancelled checks, or the DDS Individual and Family Grant Provider Payment Log(s), if applicable, showing how you spent the grant funds on the approved items or services before DDS will approve any additional Individual and Family grants.
* You are required to keep original receipts, cancelled checks, or DDS Individual and Family Grant Provider Payment Log, if applicable, for three (3) years as DDS will be conducting random audits.

**Your signature below indicates that you have received $«AmtApproved» from DDS to purchase «DetailedRequest»** **on behalf of («FirstName» «LastName»), that you spent the money as indicated below, and you agree to maintain records of grant funds spent for three years.**

***Please make sure to fill out the grid below with above approved item or service and the amount spent.***

|  |  |
| --- | --- |
| **Approved Item or Service** | **Amount Spent** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**\***Unspent grant funds or grant funds used for another purpose (without permission) must be returned to DDS before another grant can be considered. Please return in a check or money order made payable to: Treasurer, State of Connecticut and send to the attention of DDS Individual and Family Grant Program 25 Creamery Road, Cheshire, CT 06410.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_/\_\_\_\_/\_\_\_

 **Payee’s Signature**

**Payee’s E-mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Please return this form with documentation of how the money was spent by 09/30/YYYY***

***Mail to: DDS Individual and Family Grant Program 25 Creamery Road, Cheshire, CT 06410, or***

***Fax to (860) 622-2657, or E-mail to*** ***DDS.WR.Individual-FamilyGrants@ct.gov***

**«CM\_FirstName» «CM\_LastName»**