# Disability Accommodation Reimbursement Grant Request Form

CNCS is required by the Privacy Act of 1974, as amended, (5 U.S.C. 552a) to tell you what personal information we collect and how it will be used: Your personal information is requested pursuant to the National Service Trust Act of 1993 (42 USC 12611), section 12617. It will be used to assess eligibility for AmeriCorps State and National grantees to receive reimbursement for reasonable accommodations to due member disability. Routine uses of this information may include assessing such eligibility. This request is required for AmeriCorps State and National grantees receive reimbursement for reasonable accommodation.

PUBLIC BURDEN STATEMENT: Public reporting burden for this collection is estimated to average 9 minutes per submission, including reviewing instructions, gathering and maintaining the data needed, completing the form, and reviewing the collection of information. Comments on the burden or content of this instrument may be sent to the Corporation for National and Community Service, Attn: Amy Borgstrom, 250 E. Street SW, Washington, D.C. 20525. You are not required to respond to the collection unless the OMB control number and expiration date displayed on page 1 are current and valid. (See 5 C.F.R. 1320.5(b)(2)(i).)

OMB Control Number 3045-0179

Expiration Date 1/31/2023

*Please provide all the requested information to ensure timely processing of your request. Requests are not complete unless a receipt is attached.*

1. Were outside community resources consulted in securing partial funding for or arranging accommodation, such as coordinating with the Department of Vocational Rehabilitation?

   No ____ If Yes, please describe:
2. Name of Applying Organization:
3. Grant Number:
4. Organization Single Point of Contact Name for Request:
5. Single Point of Contact Email Address:
6. Single Point of Contact Telephone Number:
7. Attention to and address to which the check should be remitted:

   **Note: The prime applicant must indicate knowledge and approval of the accommodation reimbursement request. <u>All payments will be made to the prime grantee only.</u>**
8. Member NSPID(s):

9. Type of Disability:
10. Type of Accommodation:
11. Please provide a brief statement as to how the accommodation helps the member(s) achieve full participation in their service assignment(s):
12. Requested Reimbursement Amount: $
13. Is this a one-time reimbursement request or a quarterly request for multiple reimbursements?

    One-time _____ Quarterly _____

    Please batch multiple requests into quarterly submissions with an itemized summary.

14. If this is not a one-time request and you foresee batching receipts on a quarterly basis, what is your projected cost for the fiscal year for this member (please provide cost, not a range): $

The completed request form must be submitted via email to Accommodations@cns.gov with organization name and the NSPID in the subject line of the email.

Reimbursement payments will be made on a first-come, first-served basis until funds are exhausted once a completed request form is submitted with attached receipts