

Disability Accommodation Reimbursement Grant Request Form

This form is used for AmeriCorps State and National programs that request reimbursement for funds spent to accommodate one or more members with disabilities. Because a member may be sensitive about the request to disclose their need or reason for an accommodation, the information requested on this form, which might identify the member, should only be used and disclosed to process this reimbursement request, for aggregate reporting, and other crucial reasons which are legally permitted. The authority for this reimbursement request includes the National and Community Service Act of 1990, as amended (42 USC 12501 et seq., see specifically sections 12592 and 12639). Please see the Instructions for further information about this form.

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. All payments will be made to the prime grantee only.

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): \$

Individuals may want to limit the number of people who know they require accommodations or the reason for those accommodations. For that reason, only share the information on this form when absolutely necessary. Due to the nature of the request, please password protect the form or email accommodations@cns.gov for instructions for sending the form securely.

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