APPLICATION FOR FAMILY REIMBURSEMENT SERVICES
A Funding Source of Last Resort

1. **PERSONAL DATA: (please print)**

Name of Person with Disability: ____ Date of Birth: ___________________

Address: ____ City: ___________________ State: ____ Zip: ________

County: _______________________ Telephone: (____)____________________

Name of Parent/Relative: ____ Number of People in the home: _____

TABS #: ______ Medicaid #: ______ Check if the individual Receives: ___Self Direction ___CSS ___HCBS Waiver

Developmental Disability

_____Intellectual Disability _____ Epilepsy (seizures) _____ Cerebral Palsy _____Neurological Impairment

_____Autism _____Traumatic Brain Injury Other: ____

Service Coordinator Or Social Worker

____________________________________ ____ ____________________

Name Agency Phone #

2. **HAVE YOU APPLIED FOR FUNDING FROM PRIMARY MEDICAL INSURANCE, INCLUDING FLEXIBLE SPENDING ACCOUNT, OR OTHER RESOURCES?** (i.e. Medicaid, Medicare, etc.)

___ Yes ___ No Result: ____

3. **ARE YOU RECEIVING FAMILY REIMBURSEMENT FROM ANY OTHER AGENCY?:** (add a page if needed)

___Yes ___No

Agency:___________________________________ Date:______________ Amount:______________

Agency:___________________________________ Date:______________ Amount:______________

4. **WHAT IS THE ITEM(S) OR SERVICE REQUESTED FOR REIMBURSEMENT FOR THIS APPLICATION?**

____

Total Amount Requested: $_____________ Period of time requesting for:____

Cost of Item(s) $_______ If Service, how much per hour or session $_______ Amt requesting for Service $________

5. **HOW MANY HOURS OF DAY/EVENING RESPITE ARE YOU REQUESTING:** __________

6. **HOW MANY OVERNIGHT RESPITES ARE YOU REQUESTING (LIMIT 1 PER MONTH):** __________

7. **LIST OTHER REIMBURSEMENT AGENCIES APPLIED TO FOR THIS PARTICULAR REQUEST:**

Agency: _____________________________________Date:__________ Result: _________________________________

Agency: _____________________________________Date:__________ Result: _________________________________

8. **HOW DOES THIS REQUEST DIRECTLY RELATE TO THE INDIVIDUAL'S DISABILITY? (Please use space below or add a page; be specific and provide justification letters from clinical or medical professionals separately as appropriate)**

Answer question #8 here:

9. CHECKLIST OF REQUIRED DOCUMENTS: (Please attach documents to this application)

____ Original Receipts or Invoice (list which agency has the originals if copies are submitted)
____ Letter from Physician or Professional to Support Reimbursement Request (if applicable)
____ Notice of Decision or other OPWDD Eligibility Document Approved by the Access Team (if current documentation is not on file with provider agency)

CERTIFICATION OF APPLICANT

I certify that all of the above information is correct and that no other funding source is available to meet this need. I understand that incomplete forms will not be processed and will be returned to me for completion. I understand that requests submitted after the first of any month will be prorated for the remaining portion of the month. I understand that, for purpose of coordination of service, information may be shared with and received by other agencies you do business with.

Parent/Guardian Signature: ____ Date: _____________

Please mail* your application and attached documents to:

Amy DeAngelis
Community Services/FSS
Arc of Seneca Cayuga
1521 Clark Street Road
Auburn NY 13021

*Documents cannot be faxed or emailed. OPWDD regulations require us to have original signatures and receipts for all interactions.