Family Support Services

Family Reimbursement

Care Coordinator: Please complete and submit with the application packet

Name of Individual: _____

_____ Completed Application (Original only)- (**Required)**

_____ Confirmation of Eligibility – (**Required with first application for the calendar year) (circle one)**

- NOD
- MSC approval letter
- Eligibility committee approval letter

_____ DDP-1 to add

_____ Original Receipt(s) **(Required)**

_____ Original Respite Logs **(Required) – Please make sure that time is marked A.M. or P.M., hours are totaled and that the provider has initialed and signed along with family member**

_____ Clinical justification (if applicable)

_____ Recommendation and Prescription by a physician for all supplement and diet requests **(Required per agency guidelines)**

_____ Most Recent Self-Direction Expense Report (if applicable)

If any of the required paperwork is not submitted, the complete application will be returned

OPWDD REGION 1 FSS FAMILY REIMBURSEMENT APPLICATION

Application must be filled out completely in order to be considered

1. NAME OF INDIVIDUAL WITH DISABILITY:

1a DATE OF BIRTH:	1b. TABS NO.:
1c. ADDRESS (Street/Town/Zip):	
1d. COUNTY:	1e. NUMBER OF PEOPLE IN THE HOME:
2. NAME OF PARENT / RELATIVE / GUARDIAN:	
2a. PARENT / GUARDIAN EMAIL:	2b. PARENT / GUARDIAN PHONE #:
3. CARE MANAGER'S NAME:	3a. CARE MANAGER'S ADDRESS (Street/City/Zip):
3b. CARE MANAGER'S EMAIL:	3c. CARE MANAGER'S PHONE #:

4. FISCAL INTERMEDIARY (If Applicable- Name/Agency/Phone/Email):

4. DIAGNOSIS – PLEASE CHECK ALL THAT APPLY PER OPWDD

☐ Intellectual Disability ☐ Traumatic Brain Injury – TBI ☐ Other

☐ Autism ☐ Cerebral Palsy

☐ Epilepsy (seizures) ☐ Neurological Impairment

5. WHAT IS THE ITEM (S) OR SERVICE REQUESTED FOR REIMBURSEMENT – PLEASE DESCRIBE:

TOTAL AMOUNT REQUESTED ON THIS APPLICATION:

* IS THIS ITEM/SERVICE AN IMMEDIATE CRISIS SITUATION AS IDENTIFIED IN THE GUIDELINES? Please check one:

YES ☐ NO ☐

6. HAVE YOU TRIED FOR FUNDING FROM PRIMARY MEDICAL INSURANCE, INCLUDING FLEXIBLE SPENDING ACCOUNT OR OTHER SOURCES SUCH AS MEDICAID, MEDICARE, SELF DIRECTION, HCBS WAIVER – ENVIRONMENTAL MODIFICATIONS OR ASSISTIVE TECHNOLOGY, ETC.

YES ☐ NO ☐ **RESULTS**

7. LIST ALL REIMBURSEMENT APPLIED FOR AND/OR RECEIVED THIS CALENDAR YEAR: (add a page if needed): This information **MUST** be reported. Please be advised that $1,500 is the maximum total amount that may be reimbursed. If you have a large reimbursement request that exceeds an agency internal cap and you are submitting to multiple agencies for partial reimbursement, you must indicate this in the spaces below.

AGENCY	DATE	AMOUNT	APPROVED	DENIED	PENDING

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

☐ **Notice of Decision or other OPWDD Eligibility Document approved by DDRO (If current documentation is not on file with provider agency.)**

☐ **Original signed application, original receipts/invoice, respite verification forms. (If original receipt has been submitted to another agency for partial reimbursement, list what agency has the original.)**

☐ **Clinical justification / letter from physician or clinician if the request is for a clinical item / service**

☐ **If enrolled in Self-Direction, a copy of the most recent self-direction expense report or budget which verifies that Family Reimbursment is accounted for.**

9. HOW DOES THIS REQUEST DIRECTLY RELATE TO THE INDIVIDUAL'S DISABILITY? Please add a page or reply in the area below. Be specific and provide justification as appropriate.

In the event that a claim for goods or services is discovered to be fraudulent, the agency to which that reimbursement application was submitted is to be notified (if not the discovering entity) and will investigate the request in question and all documentation provided with the reimbursement request. In the event that the fraudulent claim is confirmed, the individual/family will be required to pay the amount reimbursed back to the agency (if the service/good was already reimbursed) and will be suspended from any future reimbursement for goods and services for a period of time determined by the agency and OPWDD. The recipient of the reimbursement may also be subject to legal actions as determined by the agency and OPWDD.

***I HAVE READ THE STATEMENT ABOVE AND UNDERSTAND THAT INFORMATION RELATED TO MY REQUEST FOR REIMBURSEMENT MAY BE MUTUALLY SHARED WITH AND/OR RECEIVED FROM OTHER AGENCIES WITHIN THE OPWDD REGION 1 DISTRICT:**

10. Name of Parent/Relative signing form:	10a. Date Completed:

10b. **Parent Signature**:

_____

*ORIGINAL SIGNED APPLICATION MUST BE SUBMITTED

12/9/2019

Please send completed application to: (*Incomplete applications will be returned)*

People Inc.
Attn: FRP Coordinator
280 Spindrift Drive
Williamsville, NY 14221