

Universal Application for FAMILY REIMBURSEMENT SERVICES
A funding source of LAST RESORT

All items with (*) MUST be completed for application to be accepted and processed

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

Name of Person with the Disability: _____ Name of Parent or Relative: _____
Address: _____ Primary Diagnosis: _____
City: _____ Zip: _____ County: _____ Autism Cerebral Palsy
 Mental Retardation Epilepsy
Phone #: _____ Traumatic Brain Injury/date occurred _____
School/Day Program: _____ Neurological Impairment _____
Person's Date of Birth: _____ Other _____
Person's Medicaid #: _____ Male or Female: _____
Person's Social Security #: _____ - _____ - _____ Number of People in the home: _____
Person's TABS ID #: _____

***2A. RESOURCES ATTEMPTED FOR FUNDING OF THIS PARTICULAR ITEM OR SERVICE:**

Have you tried for funding from Primary Medical Insurance, including flexible spending accounts? Yes No
Result: _____ List any charities contacted: _____
Have you tried for funding from Medicaid? Yes No Result: _____

***2B. List other reimbursement agencies applied to for this particular request:**

Agency: _____ Date: _____ Result: _____
Agency: _____ Date: _____ Result: _____
Agency: _____ Date: _____ Result: _____

3A. CHECK IF YOU OR YOUR FAMILY RECEIVES ANY OF THE FOLLOWING:

Medicare Medicaid SSI (Supplemental Security Income) SSD (Social Security Disability)
 Private Health Insurance (List Name of Carrier) _____

***3B. LIST ALL REIMBURSEMENT AMOUNTS FROM OTHER AGENCIES THIS CALENDAR YEAR:** (add a page if needed)

Date: _____ Amount: _____ Date: _____ Amount: _____ Date: _____ Amount: _____

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

Total Amount Requested: \$ _____ Period of time requesting for: _____

Cost of Item(s) \$ _____ If Service, how much cost per hour or session \$ _____ Amount requesting for Service \$ _____

***5A. HOW DOES THIS REQUEST DIRECTLY RELATE TO THE INDIVIDUAL'S DISABILITY?** (Please add a page.)

***5B. HOW WILL THIS REIMBURSEMENT ENHANCE THE QUALITY OF YOUR FAMILY LIFE?** (Please add a page.)

6. CHECK HERE IF THE INDIVIDUAL RECEIVES: Medicaid Service Coordination (MSC) NYS Cares
 HCBS Waiver Services Consolidated Supports Services

***7. SERVICE COORDINATOR OR SOCIAL WORKER:**

Name	Agency	Phone #	Fax #
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***8. CHECKLIST OF REQUIRED DOCUMENTS:** (Please attach to this application)

Notice of Decision or other OPWDD Eligibility Document Approved by the Access Team
(If already on file with applying agency within the calendar year, no need to send it again)
 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)
 Proof of NYS Cares Enrollment (if applicable)

***I UNDERSTAND THAT FOR THE PURPOSE OF REIMBURSEMENT SERVICES, INFORMATION MAY BE SHARED WITH AND RECEIVED FROM OTHER AGENCIES:** _____

Original Family Signature
No photo copies accepted

_____ Date

**Final determination of eligibility for Reimbursement Services will be determined by
The Finger Lakes Developmental Disabilities Services Office**