APPLICATION FOR FAMILY REIMBURSEMENT SERVICES
A Funding Source of Last Resort
Goods and Services

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: $_____

5. **HAVE YOU APPLIED TO OTHER REIMBURSEMENT AGENCIES APPLIED TO <u>FOR THIS PARTICULAR REQUEST</u>:** ___Yes ___No

Agency:_____ Date:_____ Amount:_____

Agency:_____ Date:_____ Amount:_____

6. **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. If payment is to be mailed directly to the Vendor, please indicate below).**

Answer question #6 here:

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

____ Receipts or Invoice for this request

____ Letter from Physician or Professional to Support Reimbursement Request (if applicable)

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 also understand this is a reimbursement service. 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, Program Secretary
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.**