OPWDD FSS FAMILY REIMBURSEMENT APPLICATION

Application must be filled out completely in order to be considered

[For: ADAPT Community Network]

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:

Please note - camp can only be reimbursed if the camp has a permit by the New York State Department of Health and/or Local Department of Health pursuant to Subpart 7 of the New York State Sanitary Code (see 10 NYCRR Subpart 7).

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**

6a. WHAT SERVICES ARE YOU RECEIVING EITHER THROUGH THE HOME AND COMMUNITY BASED (HCBS) WAIVER AND/OR OPWDD STATE PLAN SERVICES?

☐ RESPITE ☐ DAY HABILITATION ☐ LIVE-IN CAREGIVER ☐ PREVOCATIONAL SERVICES

☐ RESIDENTIAL HABILITATION ☐ SUPPORTED EMPLOYMENT ☐ COMMUNITY TRANSITION SERVICES

☐ FISCAL INTERMEDIARY ☐ INDIVIDUAL DIRECTED GOODS AND SERVICES ☐ SUPPORT BROKERAGE

☐ ASSISTIVE TECHNOLOGY – ADAPTIVE DEVICES ☐ COMMUNITY HABILITATION ☐ ENVIRONMENTAL MODIFICATIONS

☐ FAMILY EDUCATION & TRAINING ☐ INTENSIVE BEHAVIORAL SERVICES ☐ PATHWAY TO EMPLOYMENT

☐ VEHICLE MODIFICATIONS ☐CARE COORDINATION SERVICES ☐ CRISIS SERVICES FOR INDIVIDUALS WITH INTELLECTUAL/DEVELOPMENTAL DISABILITIES

☐ARTICLE 16 CLINIC

7. LIST ALL REIMBURSEMENT APPLIED FOR AND/OR RECEIVED THIS CONTRACT YEAR: (add a page if needed): This information **MUST** be reported. Please be advised that $3,000 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 Reimbursement 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.

Families may submit requests for Reimbursement to the RO or a FSS Reimbursement provider agency at any time, depending upon which entity administers the reimbursement program in that region, using the form provided by the Family Reimbursement provider agency or obtained from the individual's Care Manager or Care Coordinator. Funds are available only on a contract year basis. Any authorized, but unused, reimbursements may not be carried over by a receiving family from one year to the next. For self-directing individuals, verification is made to ensure that the FSS program is included in the current budget. Inclusion of funding in the budget does not guarantee that the request will be approved. Reimbursement requests must be consistent with FSS guidelines. Applications may be submitted to any of the Family Reimbursement Program providers by individuals, families, case managers or advocates. Anything submitted more than 90 days after purchase/occurrence will be awarded per the discretion of the Reimbursement Program provider. Applications that are not filled out in full will be returned, and payment will be delayed.

***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. Print Name of Parent/Guardian signing form:	10a. Date Completed:
10b. **Parent/Guardian Signature**: _____ *ORIGINAL SIGNED APPLICATION MUST BE SUBMITTED	
11. Application Submitted By Parent or Care Coordinator:	11a. Date Submitted:

03/2022

Please ensure this checklist is complete prior to submitting your Family Reimbursement (FR) application ($3,000 Cap):

1. Myself or my loved one has OPWDD eligibility and lives at home with their family within the 5 Boroughs. ☐ Yes
2. Complete application, all fields are completed. ☐ Yes
3. For Self -Direction, copy of the budget is included, ADAPT Family Support Services listed and FR Cap. ☐Yes, N/A ☐
4. Included a copy of a current Level of Care, Notice of Decision, or Psychological. ☐ Yes
5. Included a copy of a current Life Plan with ADAPT Family Support Services listed in Section 5. ☐ Yes
6. All receipts are dated within the fiscal year July 1, 2022, to June 30th, 2023. ☐ Yes
7. Included Proof of Purchase for Debit/Credit online purchases Including Bank and/or Credit card statements. ☐Yes, N/A ☐
8. All classes, goods, and services (***Including clothing***) submitted for (excluding camp) are accompanied by a medical justification letter from a medical practitioner including a license #. ☐ Yes
9. This is a program of last resort, I have exhausted all other funding sources, including Medicaid. ☐ Yes
10. Medicaid denial letter required for all durable medical equipment, items or medical any requests. ☐ Yes, N/A ☐

Camp Only $3,000 Cap (FR Program can reimburse the family or pay the camp directly)

1. All camp invoices or receipts are dated and attended within the fiscal year July 1, 2022, to June 30th, 2023, ☐ Yes
2. Camp bill or invoice includes an itemized breakdown including days attended, sessions and pricing ☐ Yes
3. Included a copy of the camp's operating certificate – issued by the Department of Health ☐ Yes
4. For Self -Direction, copy of the budget is included, ADAPT Family Support Services listed and FR Cap. ☐Yes, N/A ☐
5. Included a copy of a current Level of Care, Notice of Decision, or Psychological. ☐ Yes
6. Included a copy of a current Life Plan with ADAPT Family Support Services listed in Section 5. ☐ Yes
7. Included Proof of Purchase for Debit/Credit online purchases Including Bank and/or Credit card statement if invoice was paid upfront. ☐ Yes, N/A☐