OPWDD REGION 1 Universal 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: ___CSS ___HCBS Waiver

Developmental Disability:
_____Intellectual Disability _____ Epilepsy (seizures) _____ Cerebral Palsy _____Neurological Impairment
_____Autism _____Traumatic Brain Injury Other: _____

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

___ Yes ___ No Result: _____

3. LIST ALL REIMBURSEMENT AMOUNTS RECEIVED THIS CALENDAR YEAR: (add a page if needed)

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

Agency: _____ Date: _____ Amount: _____ Agency: _____ 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 $_____

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

Agency: _____ Date: _____ Result: _____

Agency: _____ Date: _____ Result: _____

Agency: _____ Date: _____ Result: _____

6. HOW DOES THIS REQUEST DIRECTLY RELATE TO THE INDIVIDUAL'S DISABILITY? (Please add a page or reply on back of application, be specific and provide justification as appropriate)

7. SERVICE COORDINATOR OR SOCIAL WORKER:

Name	**Agency**	**Phone #**	**Fax #**
_____	_____	_____	_____

8. CHECKLIST OF REQUIRED DOCUMENTS: (Please attach 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)**

******Final determination of eligibility for Reimbursement Services will be determined by OPWDD******

(OVER)

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:**

_____ _____

Original Family Signature (No photo copies accepted) **Date**

Optional area to answer question #6:

Please return application to:

CP Rochester
1000 Elmwood Avenue, Suite 900
Rochester, New York 14620
ATTN: Anne Benjamin