

**INSTRUCTIONS TO COMPLETE THE OPWDD – FSS FAMILY REIMBURSEMENT APPLICATION
AND REQUIRED SUPPORTING DOCUMENTS**

SECTION #1:

- Name of Individual applying for reimbursement
- Date of Birth
- TABS ID Number
- Full Mailing Address
- County of Residence
- Number of People residing in the home

SECTION #2:

- Name of Parent/Relative/Guardian
- Parent/Guardian Email Address
- Parent/Guardian phone Number

SECTION #3:

Complete this section if the applicant is part of a Care Coordination Organization

- If the applicant has a Care Manager, please indicate on the side whether or not the applicant has a current **Life Plan** (*if they do, we will need a copy of this document*)
- If the applicant does not have a Care Manager, please put "N/A" in this section

SECTION #4:

Complete this section if the applicant is enrolled in Self-Direction with a budget that has launched

SECTION #5:

- Check off all diagnosis that apply to the applicant
- Other: Please describe

SECTION #6

- List the goods and/or services the applicant is looking to reimbursed for
- Attach an anticipated dollar amount for each item
- Indicate the **TOTAL \$\$\$\$ AMOUNT REQUESTED ON THIS APPLICATION** (*not to exceed \$3000.00*)
- Indicate whether this is a **CRISIS** situation

SECTION #7:

- Indicate if you have tried to get funding prior through other sources (i.e., Medicaid, Medicare, Self-Direction, HCBS Waiver, etc. *(If so, indicate the results of your attempts)*)
- Indicate whether or not the applicant is enrolled in Medicaid
- Indicate whether or not the applicant is enrolled in the HSBS Waiver Program.
- If the applicant is receiving HCBS Waiver services, please check off those boxes that apply
- Indicate whether or not someone residing in your home is receiving payment to care for the applicant receiving services

SECTION #8:

- In this section, please list all reimbursement funds applied for with OTHER agencies. List the agency name, the date of reimbursement request, the amount requested and the status of the request. This helps us identify how much of the \$3000 maximum reimbursement is still available.
- If you did not apply for reimbursement with another agency this year, please put "N/A" in this section

SECTION #9:

This is a checklist of the documents attached to the application

- a. Signed application box should always be checked
- b. Clinical Justification box should be checked if a letter of justification has been provided by a physician or clinician
- c. Check this box if the applicant is enrolled in Self-Direction *(if so, we will need a copy of the current budget)*
- d. Check this box if the applicant is enrolled in a Care Coordination Organization *(if applicable, we will need a copy of the most current Life Plan)*

SECTION #10:

In this section, please describe how reimbursement for the requested goods/services directly relates to the applicant's disability

SECTION #11:

- Name of the Parent/Guardian *(printed)*
- Date Completed
- Signature of the Parent/Guardian

SECTION #12:

If submitted by a Care Coordinator/Manager, please include their contact information here

When submitting your application, please include all required documents as detailed above

REQUIRED DOCUMENT ATTACHMENTS FOR PROCESSING:

1. OPWDD FSS Family Reimbursement Application (all four pages)
2. Copy of the Decision Letter from NYS authorizing OPWDD Eligibility (permanent or provisional *)
3. A copy of the applicant's current Life Plan (if applicable)

** If the applicant has Provisional OPWDD Eligibility, they will be considered for approval up until the age of 8 years of age. After age 8, Permanent OPWDD Eligibility is **REQUIRED** for consideration*

If you have a question that is not addressed in these instructions, please email Leonard Giarraputo at lgiarraputo@ahrc.org