NEW YORK STATE OF OPPORTUNITY. Office for People With Developmental Disabilities

2/25/2025

Office for Persons with Developmental Disabilities
Instructions for Family Support Services (FSS) Family Reimbursement Application

Section 1: Individual's Information

1. Name of Individual Receiving Services: The individual's legal name (First, Last). Identify suffix as it applies (e.g.: Jr., III).

1a. Date of Birth: The individual's date of birth in Month/Day/Year (MM/DD/YYYY) format**.**

1b. *TABS No.: The TABS, or Tracking And Billing System, as the unique, 5- or 6-digit identification number specific to each OPWDD eligible individual. ***The TABS number can be located on various OPWDD specific documents, including the OPWDD's Determination of Developmental Disability ("Eligibility") letter, or, as appropriate, Individual's Life Plan or Notice of Decision/Authorization of OPWDD Services letter*

1c. Address (Street/Town/Zip): The individual's home address. Include the street, apartment number (if appropriate), city/town, state, and zip code.

1d. County: The county in which the individual resides (e.g.: Kings, Otsego, Albany)

1e. Number of People in the Home: Including the individual, identify total number of people residing within the individual's home [on a full or part time basis].

Section 2: Caregiver Information

2. Name of Parent/Guardian/Relative: The name of the parent or caregiver (First, Last). Identify suffix as it applies (e.g.: Jr., III).

2a. Parent/Guardian Email: The email address of the Parent/Guardian. If none, leave blank.

2b. Parent/Guardian Phone #: The Parent/Guardian's primary contact (phone) number, including area code.

Section 3: *Care Manager's Information (As Applicable)

Complete if enrolled in Care Management, otherwise leave blank and skip to Section 4.

***Care Manager's information can be found on page 1 of individual's current Life Plan*

3. Care Manager's Name: The name of the Care Manager (First. Last).

3a. Care Manager's Address: The Care Manager's mailing address. Include the street, apartment number (if appropriate), city/town, state, and zip code.

3b. Care Manager's Email: The email address of the Care Manager. If none, leave blank.

3c. Care Manager's Phone #: The Care Manager's primary contact (phone) number, including area code.

Section 4: Fiscal Intermediary Information (As Applicable)

Complete if participating in Self Directed Services (SDS), otherwise leave blank and skip to Section 5

4. Fiscal Intermediary: Name (of primary contact person), Agency (name of agency), Phone (contact telephone number, including area code), and Email (email address of FI contact person).

Section 5: Diagnostic Information

5. Diagnosis- Please Check all that apply per OPWDD: Check box as appropriate for all/any identified diagnosis/diagnoses listed in Section 5. If Other, identify in blank area provided.

Section 6: Reimbursement Information

6. What is the Item(s) or Service Requested for Reimbursement—Please Describe:

Provide specific and descriptive information about the item (good) or service which reimbursement is being sought for. For items/goods, this should include a brand/model of item, size, color preference, etc. If service, provide the frequency of the service (e.g.: one time, twice monthly, weekly) and duration (e.g.: ongoing for 6 months, January 2024-July 2024).

**Note Camp requirement disclaimer if applying for Camp reimbursement funding*

Total Amount Requested on This Application: List amount of reimbursement requested in the blank space provided. Amount should exclude Shipping and Handling fees, Sales Tax, and/or caregiver contribution (as applicable). Amount requested should not exceed the $3000 annual cap for combined FSS FR services. ***This section should not be left blank***.

Is this Item/Service an Immediate Crisis Situation, or Emergency Reimbursement, as identified in the Guidelines: Check box Yes/No as appropriate. See ADM-2022-02**R** Section D.1b (pages 4-5) for Emergency reimbursement guidelines in ADM-2022-02**R** and Section D.2c. (page 6) for process.

Section 7: Resource Availability and Service & Support Information

7. *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.: Check box Yes/No as appropriate. Results from pursuing alternative funding sources should be briefly documented in space provided. **Alternative funding sources should first be explored prior to applying for FSS FR funds. Refer to Family Support Services (FSS) Reimbursement FAQ document for more details.*

7a. Is the individual enrolled in Medicaid?: Check box Yes/No as appropriate.

7b. *What services are you receiving either through the Home and Community Based Services (HCBS) Waiver and/or OPWDD State Plan services?: Check box for any/all services as appropriate. *******Current service enrollments can be located on various OPWDD specific documents, including individual's Life Plan or Notice of Decision, as appropriate.*

7c. *Is anyone residing in your home receiving payment to provide care to the individual receiving services?: Check box Yes/No as appropriate. **Inclusive but not limited to Kinship Care stipends, CDPAP, etc.—see ADM-2022-02-**R** and Family Support Services (FSS) Reimbursement FAQ document.*

Section 8: FSS FR Reimbursement History/Application Outcome Information

8. List all reimbursement applied for and/or received this contract year: *This information MUST be reported. Please be advised that $3,000 is the maximum total amount that may be reimbursed annually.*

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*:** For each application submitted for the ***contact year (January 1st – December 31st for Regions 1, 2, 3 and 5; July 1st -June 30th for Region 4), identify agency, date of application submission, and amount requested in spaces provided. Check box as appropriate to identify if application was Approved/Denied/ Pending. Each line should denote each agency and application submitted with outcome. *Additional pages should be added if needed.*

Section 9: Required Documents for Application

9. Checklist of Required Documents: Check box as appropriate for items attached to completed application. These documents may include:

- Signed application, receipts/invoice (photocopies and digital copies are acceptable), respite verification forms. (If receipt has been submitted to another agency for partial reimbursement, list what agency has the receipt).
- Clinical justification/letter from physician or clinician if the request is for a clinical item/service—*see ADM-2022-02-**R** and Family Support Services (FSS) Reimbursement FAQ document for specifics on clinical justifications.*
- 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. *FSS FR MUST be included in the individual's SDS budget with information as required.*
- ***If enrolled with a CCO***, a copy of the most recent life plan with FSS Family Reimbursement properly documented. *FSS FR (specific to each provider agency) MUST be included in the individual's Life Plan/Life Plan addendum with information as required in Section I and V of that plan.*

Section 10: Justification Information

10. 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.

Provide detailed information about how this service/item will benefit the individual and an overview of how it is related to the individual's I/DD or OPWDD qualifying disability. ***This section should not be left blank***.

Section 11: Acknowledgement

11. Print Name of Parent/Guardian signing form: Print Name of individual's Parent/Guardian consistent with Name of Parent/Guardian/Relative provided in Section 2.

11a. Date Completed: Date application form was completed in Month/Day/Year (MM/DD/YYYY) format**.** *Application should NOT be dated in advance to purchase/service delivery if reimbursement is being sought.*

11b. Parent/Guardian Signature: Parent/Guardian to sign in this section. **Caregiver signature is a requirement for submitting application.*

12. If Submitted by Care Coordinator, Print Name: *As applicable,* print name of individual's Care Coordinator.

12a. Name of Care Coordination Organization (CCO): *As applicable,* name of Care Coordination Organization (CCO) individual is enrolled with (e.g.: Prime Care Coordination, Care Design Inc., etc.)**.**

13. Date Submitted: Date application is submitted for consideration. Enter date in Month/Day/Year (MM/DD/YYYY) format**.**

Submit the completed Application, with all required attachments (as applicable) to the FSS FR Provider agency of choice or Developmental Disabilities Regional Office, DDRO (for direct requests only).