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

Family Reimbursements Tracker Instructions
2/25/25

Column	Instructions
A	Enter OPWDD DDRFO. Choose from Dropdown Menu
B	Enter OPWDD District. Choose from Dropdown Menu
C	Enter County of Residence of the individual receiving services
D	Enter if request is an Emergency ("Crisis") reimbursement. Refer to ADM-2002-02**R.** Choose from Dropdown Menu
E	Enter FSS Provider Agency (or DDRO, if direct submission)
F	Enter Individual's Last Name
G	Enter Individual's First Name
H	Enter Individual's TABS ID #
I	Enter if the Individual is actively enrolled in Medicaid. Choose from Dropdown Menu. **Any information relevant to Medicaid status which may impact FSS FR application should be listed in Notes (Column W).*
J	Enter if the Individual is currently connected with a Care Manager. Choose from Dropdown Menu
K	Enter if the Individual is enrolled in a HCBS Waiver program (i.e.: OPWDD's HCBS Waiver, Children's Waiver). Choose from Dropdown Menu
L	Enter if Individual receiving services is enrolled in Self-Direction Services. Choose from Dropdown Menu. ***If yes*, indicate that a SDS Denial been received *(required for SDS participants with an active budget).*** **Note FSS FR Service, Provider Agency, and information required per ADM for SDS participants should be appropriately documented in Life Plan and approved SDS Budget*
M	Enter the name of the person (Payee) receiving the reimbursement. If Direct Purchase, enter the name of the business/organization payment will be issued to
N	Enter date the reimbursement was requested (original date of application submission)
O	Enter date the reimbursement was approved by FSS Provider Agency's Family Reimbursement Committee
P	Enter name of Item (Good) or Service that is being requested
Q	Enter description of Item (Good) or Service, providing 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, quantity, size, etc. For service, provide location, duration, frequency, and other information as relevant to request
R	Enter Cost of Good or Service (i.e. the total amount being requested for reimbursement. Cost of request excludes sales tax and/or S&H. If there is a family contribution towards cost, this should be noted here
S	Enter if the reimbursement is One Time only or Ongoing; if Ongoing, provide the frequency (i.e. 4 times per session at $xx per session for 6 months).
T	Offer a descriptive yet concise summary to support or justify need for item/good or service. Information should explicitly include how this item/good or service clearly is related to the Individual's I/DD and how it is an atypical expense not otherwise covered. If Individual is enrolled in a CCO, the justification provided should be mirrored in the Life Plan. ***Refer to FAQ Document #15 and 16 to determine if a clinical justification is required to support this request and criteria for a clinical justification**.*
U	Identify which alternative funding sources or alternatives were pursued prior to exploring FSS FR and the outcome of each inquiry. Offer confirmation that the most cost-effective items/goods or services were pursued. If not, explain why more cost-effective alternatives or funding through other sources was not chosen if they were available (e.g.: HCBS Waiver (such as environmental modifications, van modifications, or adaptive technology process; respite), SDS, community-based programs) **Supporting information should be reflected in FSS-FR Application Section 7*
V	Enter website link to the item/good or service. **Omission of this information may result in delays with processing request*
W	Enter any additional notes as needed (inclusive, but not limited to: follow up actions, correspondence, additional rationale, miscellaneous information, etc.)
X	Enter DDRFO decision on request. Choose from Dropdown Menu