SI Family Reimbursement REV. 7/18

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FOR STATEN ISLAND INDIVIDUALS ONLY

OPWDD DDRO - Region 4, Staten Island
Family Reimbursement c/o Mr. John Wynne
930 Willowbrook Rd. Bldg. 12G; Staten Island, New York 10314
PLEASE PRINT CLEARLY

For office use only
Application Reg. # OPWDD Elig / Care Manager: Date:

***Applicant Name:**_____ *** TABS ID** _____
(Individual Who Has a Developmental Disability)

*Date of Birth: ____/____/____ is the applicant living with parent? Yes ☐ No☐

Primary Diagnosis: _____

***SOCIAL SECURITY NUMBER**_____

Parent Name: _____

Parent Address: _____**APT:**_____**STATEN ISLAND, NY**

Zip Code: 103_____**Phone No.:** _____

Name of person completing application, if other than parent: _____

Agency (if any):_____ Address: _____

Telephone No.:_____***EXT:** _____ **Relationship to Applicant:**_____

Please check if the applicant receives any of the following:

Medicaid ☐ Medicaid Waiver ☐ S.S.I ☐ Insurance☐ Medicare ☐ **Self Direction ☐

**If applicant has Self Direction, funding for this service must be included in the budget.

Goods or Services Requested: _____

_____

Reason for Reimbursement: _____

_____

***Cost For Above Request:** _____

***Are you receiving any other sources of funding for this request:** Yes ☐ No ☐

If Yes – Please explain: _____

***To Whom Should The Check Be Issued?** _____

***Where should it be sent?** _____

Have You Ever Received Family Reimbursement? Yes ☐ No ☐

Most Recent Date of Your Last Award: ____/____/____ Agency(if known): _____

***- required fields**

PLEASE BE AWARE – THE FISCAL YEAR RUNS FROM JULY 1, 20XX TO JUNE 30, 20XX.

WE CANNOT REIMBURSE FROM ANOTHER FISCAL YEAR'S BUDGET

ATTACH ORIGINAL RECEIPTS TO THIS FORM FOR CONSIDERATION.

Only this standardized application will be accepted and considered for any Staten Island Reimbursement award.

Please turn application over in order to sign and complete →

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A Family Reimbursement Application may be submitted once per fiscal year. Priority will be given to those persons applying for the first time. For all other applicants, a review of previous reimbursement history will be taken into consideration. If a family is in financial crisis and needs immediate assistance, they should contact Mr. John Wynne at: 718-982-1943 for guidance.

All applicants must have established OPWDD eligibility. If you have questions regarding eligibility, call John Wynne at 718-982-1943.

Sign the appropriate statement

I agree to submit **THE ORIGINAL** bill for the requested goods or service.

Signature: _____ Date ____/____/____
Parent and/or Care Manager

OR

For families unable to make an initial outlay, please call John Wynne at (718) 982-1943.

I agree to attach an estimate for the requested goods or service. **Once the purchase is completed, I agree to submit a receipt and return any unused funds within thirty days of purchase.**

Signature: _____ Date ____/____/____
Parent

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