SI Family Reimbursement REV. 7/15

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FOR STATEN ISLAND INDIVIDUALS ONLY

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

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Application Reg. # OPWDD Elig / MSC: 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 ☐

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**

<u>PLEASE BE AWARE – FISCAL YEAR GOES FROM JULY 1 20XX, TO JUNE 30 20XX.</u>

<u>WE CANNOT REIMBURSE FROM ANOTHER FISCAL YEARS BUDGET</u>

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 every 12 months. However, 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 MSC

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.**

Signature: ______________________________ Date ____/____/____
Parent

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