

**NEW YORK STATE INSTITUTE ON DISABILITY, INC. (NYSID)**  
930 Willowbrook Road, Bldg. 41-A  
Staten Island, NY 10314  
Office Phone 718 494-6457 / Cell Phone 929 202-1115  
Fax 718 494-6461 EMERGENCIES ONLY  
Email: [info@nysidinc.org](mailto:info@nysidinc.org)

Name of Applicant \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Home Address \_\_\_\_\_ Apt # \_\_\_\_\_ Borough \_\_\_\_\_ Zip \_\_\_\_\_  
Social Security # \_\_\_\_\_ Medicaid # \_\_\_\_\_ TABS ID \_\_\_\_\_  
Diagnosis \_\_\_\_\_ OPWDD Eligibility Yes or No  
Parent's Full Name \_\_\_\_\_ Email \_\_\_\_\_  
Home Phone #/Cell Phone # \_\_\_\_\_ Family income \_\_\_\_\_  
Care Coordinator/Manager \_\_\_\_\_ Email \_\_\_\_\_  
Agency /CCO name \_\_\_\_\_  
Address \_\_\_\_\_  
Office Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

**WHAT SERVICE ARE YOU REQUESTING (ONE PER APPLICATION):  
YOU MUST ATTACH A CURRENT LEVEL OF CARE ELIGIBILITY DETERMINATION OR FULL PSYCHOLOGICAL REPORT**

1. **SPORTS & ENTERTAINMENT TICKETS** (4 tickets per family)  
\_\_\_\_\_  
Attach your prioritized list: please choose up to four venues
2. **RECREATION REIMBURSEMENT: (horseback riding, swimming, etc)**  
Include justification letter explaining why the individual partakes in the activity, original invoices/receipts  
Reimbursement is subject to approval and is not guaranteed.  
  
**AMOUNT REQUESTED \$** \_\_\_\_\_  
**CHECK IS TO BE ISSUED TO** \_\_\_\_\_
3. **CAR SERVICE REQUEST**  
\_\_\_\_\_  
Attach the car service request form. Family member must accompany the applicant – a limit of four (4) rides per family per fiscal year.
4. **FREE IN- HOME EVALUATIONS** (For non-Medicaid eligible persons only)  
Please submit an IEP, OPWDD request or letter from a doctor requesting evaluation  
Psychological \_\_\_\_\_ Psychosocial \_\_\_\_\_ Language spoken \_\_\_\_\_

**Answer all three of the following questions. Failure to do so will delay the processing of your application. It may also result in your application being RETURNED or DENIED.**

**Do You Receive Self-Direction Services? Yes or No**  
**If yes, did you include Family Support Services? Yes or No**  
**If yes, did you include NYSID SPORTS & RECREATION and/or NYSID TRANSPORTATION in your budget? Yes or NO**  
**Please provide approved: Budget Amount \_\_\_\_\_ and Date \_\_\_\_\_**

**Who is completing the application? Please circle below:**  
Parent    Self Advocate    Care Manager    Family Member/ Representative/Other \_\_\_\_\_  
(Specify)  
**Signature of Person Completing Application: \_\_\_\_\_ Date \_\_\_\_\_**

## **DIRECTIONS FOR COMPLETING THE NYSID APPLICATION**

- 1. THIS APPLICATION IS NOT TO BE USED FOR REIMBURSEMENT FOR GOODS & SERVICES. THAT APPLICATION IS AVAILABLE ON THE OPWDD WEBSITE.**  
<https://opwdd.ny.gov/system/files/documents/2022/06/attachme nt-a-family-reimbursement-application.pdf>
- 2. PRINT OR WRITE LEGIBLY**
- 3. Answer every applicable question. Failure to do so may result in your application being RETURNED or DENIED**
- 4. Answer the Self Direction Question YES or NO**
- 5. SIGN and DATE the application**
- 6. Incomplete applications will be returned**
- 7. REQUIRED DATA on all applications:**
  - **You may submit a current Level of Care Eligibility Determination; or most recent complete psychological report**
  - **Name of person with developmental disabilities, i.e. the “applicant”**
  - **Date of birth, Social Security number, Medicaid number of the applicant and Tabs ID**
  - **Address of the applicant, complete with apartment number, borough and zip code**
  - **Name of person completing the application, relationship, address, and phone number(s)**
  - **For recreational reimbursements, you must submit bills or receipts and documentation of why the individual is participating in the recreational activity.**
- 8. NYSID services are funded by OPWDD Family Support funds. They are available only to individuals with developmental disabilities who live with their families and have OPWDD Eligibility.**
- 9. WE DO ACCEPT EMAILED or mail the application to the NYSID office in Staten Island**
- 10. All applications are subject to approval, service/reimbursement is not guaranteed.**
- 11. Applications requesting an evaluation must have a copy of an IEP, OPWDD request or a letter from a Doctor requesting the evaluation.**