NEW YORK STATE INSTITUTE ON DISABILITY, INC. (NYSID)
930 Willowbrook Road, Bldg. 41-A
Staten Island, NY 10314
Phone 718 494-6457
Cell 929-202-1115
Email: info@nysidinc.org

SERVICES PROVIDED BY NYSID

- Free in-home evaluations to individuals that **DO NOT** have Medicaid for the purposes of obtaining OPWDD Eligibility for individuals residing in Queens, Brooklyn, Bronx and Staten Island. You may contact Elizabeth Sunshine at 917-699-0578 or email esunshine@nysidinc.org for additional information.

- Crisis Management Services to families in The Bronx, Brooklyn and Queens you may contact Juliet Hawkins at 917-524-4856 or email jhawkins@nysidinc.org for additional information

- Reimbursement for goods, services and camp to individuals that reside in the five boroughs. You may contact Jackie Tripodi at 929-202-1115 or email jtripodi@nysidinc.org for additional information.

- Recreation outings for individuals residing in the Bronx, Brooklyn, Queens and Staten Island. We **do not** provide recreation outings to individuals with self-direction services or reside in Manhattan. You may contact Sarah Alton at 718-494-6457 or email salton@nysidinc.org for additional information.

- Transportation services in Brooklyn, Bronx and Staten Island for medical appointments or recreation activities for an individual and members of their family. In Queens we can provide transportation to an individual attending a venue we provide tickets for. We **do not** provide transportation to individuals with self-direction services or reside in Manhattan. An individual is able to receive up to 4 transportation trips per fiscal year. You may contact John O'Grady our transportation coordinator at 917-747-9424 or email jogrady@nysidinc.org for additional information.

These services are all provided through family support contracts and can only be provided to individuals that reside home with their families and have OPWDD Eligibility (or are seeking an evaluation to obtain eligibility).

New York State Institute on Disability, Inc.

REIMBURSEMENT APPLICATION CHECKLIST FOR GOODS AND SERVICES
2024/2025 Fiscal Year

NYSID WILL ACCEPT EMAILED APPLICATIONS
INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED

ALL reimbursement application packets must include the following information.

____ NYSID Reimbursement Request Form – **Must have all questions answered**

____ OPWDD updated application has been submitted https://opwdd.ny.gov/system/files/documents/2023/05/attachment-a-family-reimbursement-application_3-27-23.pdf -Application Link
.

____ **Application Form must have ALL questions answered*****, if you answer YES to question 7c_application will not be accepted; individual is not eligible for FSS reimbursement if a household member receives payment to care for the individual*****.**

____ **Included in section 8 ALL previous reimbursement applications within this fiscal year, when multiple applications are submitted.**

____ Clinical Justification * **A clinical justification letter is required for clothing / sensory items, (supplements, mattresses, eyeglasses will need insurance denial) the letter MUST relate to the individual's disability and explain WHY they are needed. The letter must be dated, on letterhead, signed (an electronic signature is acceptable), and include the clinicians license number.**

____ Individual's **Finalized** Life Plan submitted. * **An individual's Life Plan must accompany the application. Life plan must also include the "why" the individual needs the item and "how" it is related to the individual's disability in section 1 summary; if the need is due to a behavior there must be a "plan of action" on how the behavior is being addressed and in section 5 must the life plan must include NYSID as the family support services provider (if it does not include our agency we would not be able to serve the individual).**

____ Individuals Notice of Decision from of OPWDD that reflects that the individual has OPWDD Eligibility. If the individual does not have a Life Plan**.**

____ Detailed Invoice/Receipts submitted. * **The receipts submitted must be within the fiscal year AND within 90 days of purchase. We do not accept screen shots of receipts. Recreational (swimming, music lessons, horseback riding etc.) receipts must include the individual's name, the dates the lessons were taken (we will not pay for lessons not yet taken), frequency of the lessons (weekly, monthly, etc..) with the cost of each lesson and payment method.**

____ Respite Reimbursement requests must have a completed OPWDD Respite Verification Form https://opwdd.ny.gov/system/files/documents/2022/06/attachment-b-respite-verification-form.pdf
Family must also provide receipts from the respite provider that confirms the payment amount they received. The receipt must be signed and dated.

____ Individual's With a Self- Direction Budget must include NYSID as Family Support Services Provider ***If the individual has self-direction services, they must provide a copy of the approved budget that includes the agency provider, dated of approved budget and amount approved for FSS.**

New York State Institute on Disability, Inc.
REIMBURSEMENT APPLICATION CHECKLIST
2024/2025 Fiscal Year

APPLICATIONS FOR CAMP REIMBURSEMENT

**** IF AN INDIVIDUAL IS ATTENDING A CAMP THAT BILLS FOR WAIVER/RESPITE, THEY WILL NOT BE ELIGIBLE TO RECEIVE FAMILY SUPPORT REIMBURSEMENT FOR THE BALANCE DUE TO THE CAMP. THIS WILL BE THE PARENTS' RESPONSIBILITY.***

****IF AN INDIVIDUAL HAS SELF-DIRECTION SERVICES, THEY ARE EXPECTED TO PAY FOR CAMP THROUGH THEIR BUDGET AND NOT WITH FAMILY SUPPORT SERVICES FUNDS.***

NYSID WILL ACCEPT EMAILED APPLICATIONS

INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED

ALL reimbursement application packets must include the following information.

____ NYSID Reimbursement Request Form – All Questions must be Answered

____ OPWDD updated application has been submitted https://opwdd.ny.gov/system/files/documents/2023/05/attachment-a-family-reimbursement-application_3-27-23.pdf -Application Link
*** A family member/care manager must submit the new Fully Completed State Application**

___ **Application Form must have ALL questions answered**, ***if you answer YES to question 7c_application will not be accepted; individual is not eligible for FSS reimbursement if a household member receives payment to care for the individual.***

____ *Justification letter* **** Camp applications do not require clinical justification; however, a justification letter is required explaining why the individual attends camp***

____ Individual's Finalized Life Plan submitted. *** An individual's Life Plan must accompany the application. Life plan must also include the "why" the individual needs the item and "how" it is related to the individual's disability in section 1 summary and in section 5 must the life plan must include NYSID as the family support services provider (if it does not include our agency we would not be able to serve the individual).**

____ NYS Department of Health Certificate ***** ***All camp applications must have a current department of health certificate that matches the name of the camp on the invoice/bill.***

____ Camp Invoice/Paid Receipt ****Camp invoice must include the individual's name, dates of attendance; cost of camp, amount paid or balance due. We can pay for the camp directly and will require proof of attendance by the end of the summer. *If proof of attendance is not submitted the family /camp will be expected to refund this agency for any funds provided.*** *We can only pay up to 14 days of overnight camp attendance. *We can pay for more than 14 days for day camp attendance.

____ Letter of Attestation from the camp confirming they do not bill for waiver respite for the individual.

New York State Institute on Disability, Inc.
REIMBURSEMENT REQUEST FORM
2024/2025 Fiscal Year

NYSID WILL ACCEPT EMAILED APPLICATIONS

INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED

THIS FORM MUST ACCOMPANY ALL REIMBURSEMENT REQUESTS SUBMITTED TO NYSID

You must answer ALL these questions when submitting your reimbursement request:

Individuals Name____

Tabs ID _______________ **County of Residence** _________________________

1. **Is the individual enrolled in Medicaid?** **Yes** _____ **No** _____
2. **Is the individual enrolled in Medicaid Waiver?** **Yes** _____ **No** _____
3. **Does the individual reside at home with their family?** **Yes** _____ **No** _____
4. **Is the individual enrolled in Self-Direction Services?** **Yes:** ___ **No:** ___ **Pending Budget Approval:** ___
5. **Does this item support the individual remaining at home with their family/caregiver?** **Yes:** ___ **No:**___
6. **Is the request for the item/items** **One time only:** ______ **Ongoing:** ______

   6a. If ongoing, please indicate frequency_______________________________

7. **Please provide a website link for the item. (If applicable)**

   ____

The State is allowing up to $3,000 per fiscal year which is inclusive of camp, goods and services such as clothing, recreation programs, and sensory items etc.

FSS Reimbursement Allowable and Non-Allowable Items

https://opwdd.ny.gov/system/files/documents/2024/06/fss-reimbursement-allowable-and-non-allowable-items_-revised_6.10.24-002.pdf

OPWDD FSS Reimbursement Request FAQ's

https://opwdd.ny.gov/system/files/documents/2024/06/fss-family-reimbursement-adm-faq_6.10.24.pdf

OPWDD Administrative Memorandum Guidelines for FSS Reimbursement Requests

https://opwdd.ny.gov/regulations-guidance/adm-2022-02-family-support-services-fss-reimbursement-guidelines -

* It would be advisable for a family to work with only one agency through the fiscal year for applications to be processed in a timely manner. *Applying to multiple agencies delays the processing of an application.*

If you have any questions or need more information, please call New York State Institute on Disability at 929-202-1115 / 718-494-6457or email info@nysidinc.org.

New York State Institute on Disability, Inc.

Invites families from
Brooklyn, Bronx, Queens and Staten Island to enjoy

FAMILY OUTINGS and ENTERTAINMENT EVENTS

Children and adults with developmental disabilities who live with their families and have OPWDD Eligibility may apply for a variety of events throughout New York City

YOU MAY REQUEST UP TO FOUR (4) TICKETS PER FAMILY FOR AN EVENT
***Transportation available upon request**

*Please submit an application along with a current Level of Care Eligibility Determination or Psychological Evaluation with your top **four choices** of the following venues:*

__ American Museum of Natural History
__Bronx Zoo
__Brooklyn Aquarium
__Central Park Zoo
__Intrepid Sea, Air & Space Museum
__Land of Fun (Brooklyn)
__Madame Tussaud's Wax Museum
__Movie Tickets
__New York Botanical Garden
__New York Hall of Science
__Prospect Park Zoo
__Queens Zoo
__Staten Island Children's Museum
__ Staten Island Zoo (Spooktacular)
__Brooklyn Nets (Oct-April)
__Brooklyn Cyclones (June-Sept)
__Wrestling (July and December)

__Tickets for Shows and Events at the New Victory Theater, Circus, Dave n Busters and other Venues

****

APPLICATIONS ARE PROCESSED ON A FIRST COME, FIRST SERVE BASIS

PRIORITY WILL BE GIVEN TO FAMILIES NOT PREVIOUSLY SERVED

WE DO NOT PROVIDE TICKETS FOR INDIVIDUALS WITH SELF-DIRECTION SERVICES

TICKETS ARE SUBJECT TO AVAILABILITY AND FUNDING

For more information and an application please contact

Sarah Alton - Office Phone: 718-494-6457- Email: salton@nysidinc.org

New York State Institute on Disability, Inc.
930 Willowbrook Road, Building 41-A
Staten Island, NY 10314

Revised 7/1/24

Office for People With Developmental Disabilities

Allowable Items:

- Recreation Activity/Program/Equipment
  - Integrated, community-based activity fees/supplies
  - Instrumental and music lessons/fees (e.g., guitar lessons, piano lessons)
  - Braille bingo cards, playing cards and dominoes
  - Cooking classes (not resulting in certification)
  - Theatre classes/workshops
  - Museum membership (e.g., sensory, STEM)
  - Art classes
  - Gym membership
  - Fitness classes
  - Swim lessons
  - Sports lessons/fees/expenses (e.g., Soccer, Baseball, Golf, Skiing, Bowling, Cheerleading)
  - Martial Arts lessons (e.g. Karate, Tae kwon do)
- Recreation Activity/Program Equipment, continued
  - Dance/ballet lessons
  - Equine therapy/Hippo therapy/Horseback riding
- Sensory Items
  - Balance chair
  - Bean bag chair
  - Indoor or outdoor swing
  - Mini trampoline (single user)
  - Climber
  - Fidget items/sensory toys
  - Shower head
  - Positioning cushion/wedge
  - Floor mats
  - Noise cancelling ear coverings
  - Therapy tunnel
  - Sensory Activities/crafts, as related to I/DD diagnosis

- Items/Services that are not covered or available through other means and are reviewed and approved by the Committee
- Respite (see section G of the ADM)
- Camp (see section H of the ADM)
- Electronic devices (see section J of the ADM)
- Supplements/Over-the-counter medications approved by a clinician if denied by insurance* and outlined in the individual's treatment plan as related to I/DD diagnosis
- Replacement/repair of prescription eyeglasses or hearing aids if denied by insurance*
- Legal fees related to guardianship and special needs trusts
- Clothing as a necessity due to atypical needs to include:
  - Specific clinical needs related to the intellectual/developmental disability (I/DD) (e.g., excessive chewing, destruction due to behavior or incontinence). Clinical need should be included in the Life Plan (if applicable) with a plan to mitigate the behavior (as applicable), or other appropriate documentation requested by the FSS provider and/or Regional Field Office (RFO) to substantiate the request*, *or*
  - Health/safety, environmental or functional needs (i.e. winter jacket, snow boots, etc.),
- Incontinence related items/supplies, in the absence of Medicaid and/or Third Party Insurance to cover this, or if you exceed the quantity of the product as covered by insurance.*
- Mattress/box spring purchase/replacement as an atypical expense due to documented incontinence/behavioral issues with a plan to address such behaviors (as applicable) *or* resulting from environmental hazards (e.g., bed bugs, fire/water damage)*. Requests not to exceed once every 2 years*,
- Protective mattress covers (waterproof, bedbug preventative, etc.), *and*
- Other items as deemed appropriate and reimbursable by the RFO

Non-Allowable Items:

Healthcare/Personal care:

- Items covered by Medicaid or other health insurance, including incontinence items & prescription medications/medical supplies
- Diapers if covered by insurance*
- Wipes if covered by insurance*
- Bibs
- Experimental treatments/therapies
- Dental activities
- Toothbrush
- Prescription eyeglasses if covered by insurance*
- Dermatology services
- Sedation
- Enemas
- Oral swabs, syringes
- Portable tub
- CBD or marijuana products
- Nutrisystem – weight loss program
- Personal training
- Life coach
- Exercise equipment (e.g.: elliptical machine, treadmill, free weights)

Household Expenses:

- Appliances, large and small (e.g., washing machine, dryer, blender)
- Furniture
- Mattress, *unless criteria met* *
- Home repairs*
- Rent/rental deposit*
- Maintenance items*
- Air conditioner
- Snowplow/snowplow services
- Video monitoring system
- Pool cover
- Water fountain
- Food *(as an ongoing/routine expense)**
- Bento box, water bottle

Travel/Transportation:

- Vehicles (e.g., cars, motorcycles)
- Car repairs
- Batteries (side-by-side bike, wheelchair—if covered by insurance*, etc.)
- Car fuel
- Car seat
- Hotel/lodging, mileage and travel costs
- Conference expenses
- Bicycles/Tricycles/Scooters
- Taxi service/Uber or Lyft rides
- Stroller

Fiscal Expenses:

- Real property (e.g., home or apartment related costs)*
- Finance charges
- Tax bills
- Sales tax
- Shipping fees
- Co-pays
- Fines
- Funeral expenses

Duplicative Expenses/Otherwise Covered:

- *Upgrades* to items/services covered by HCBS Waiver or other sources, including self- direction budgets (e.g., upgrading fencing materials, additional funding for a higher cost camp)
- Items/services related to/required for [Waiver based] day program participation/enrollment
- Items covered by other state paid benefits (e.g., free cell phone programs)
- Items covered by self-direction budget, *if* someone is self-directing services
- Equipment repair/replacement

<u>Non-Allowable Items, Continued:</u>

Educational Based Services/Goods:
- College courses/Certification programs
- Homeschool books
- Tutoring
- After-school programs
- Academic testing/retesting
- Items and services that an individual is eligible for in the context of their educational services (e.g., occupational therapy, physical therapy)
- ABC Mouse learning program/app

Miscellaneous Items/Services:
- Regular and ongoing subscription plans
- Cell phone purchase and cellular plans
- Data plans for iPad
- Headphones
- GPS Trackers/devices; video or audio monitoring devices
- Outdoor recreational equipment (swings, playsets)
- Typical expenses/entrance fees associated with community-based, recreational activities (e.g., zoos, theme parks)
- Luxury items (e.g., swimming pools, hot tubs)
- Concert tickets
- Clothing as a typical expense or *unless criteria met related to the person's I/DD diagnosis or health/safety need**
- Baby gates
- Other items deemed not appropriate for reimbursement by the RFO

See section I (3) of the ADM for Allowable One-Time Reimbursements of these items/services

New additions are highlighted

***Indicates proof required**

OPWDD FSS FAMILY REIMBURSEMENT APPLICATION

Application must be filled out completely in order to be considered

1. NAME OF INDIVIDUAL RECEIVING SERVICES:	
1a DATE OF BIRTH:	1b. TABS NO.:
1c. ADDRESS (Street/Town/Zip):	
1d. COUNTY:	1e. NUMBER OF PEOPLE IN THE HOME:
2. NAME OF PARENT / RELATIVE / GUARDIAN:	
2a. PARENT / GUARDIAN EMAIL:	2b. PARENT / GUARDIAN PHONE #:
3. CARE MANAGER'S NAME:	3a. CARE MANAGER'S ADDRESS (Street/City/Zip):
3b. CARE MANAGER'S EMAIL:	3c. CARE MANAGER'S PHONE #:
4. FISCAL INTERMEDIARY (If Applicable- Name/Agency/Phone/Email):	

5. DIAGNOSIS – PLEASE CHECK ALL THAT APPLY PER OPWDD

☐ Intellectual Disability ☐ Traumatic Brain Injury – TBI ☐ Other

☐ Autism ☐ Cerebral Palsy

☐ Epilepsy (seizures) ☐ Neurological Impairment

6. WHAT IS THE ITEM (S) OR SERVICE REQUESTED FOR REIMBURSEMENT – PLEASE DESCRIBE:

Please note - camp can only be reimbursed if the camp has a permit by the New York State Department of Health and/or Local Department of Health pursuant to Subpart 7 of the New York State Sanitary Code (see 10 NYCRR Subpart 7).

TOTAL AMOUNT REQUESTED ON THIS APPLICATION:

* IS THIS ITEM/SERVICE AN IMMEDIATE CRISIS SITUATION AS IDENTIFIED IN THE GUIDELINES? Please check one:

YES ☐ NO ☐

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.

YES ☐ NO ☐ **RESULTS**

7a. IS THE INDIVIDUAL ENROLLED IN MEDICAID? YES ☐ NO ☐

7b. WHAT SERVICES ARE YOU RECEIVING EITHER THROUGH THE HOME AND COMMUNITY BASED (HCBS) WAIVER AND/OR OPWDD STATE PLAN SERVICES?

☐ RESPITE ☐ DAY HABILITATION ☐ LIVE-IN CAREGIVER ☐ PREVOCATIONAL SERVICES

☐ RESIDENTIAL HABILITATION ☐ SUPPORTED EMPLOYMENT ☐ COMMUNITY TRANSITION SERVICES

☐ FISCAL INTERMEDIARY ☐ INDIVIDUAL DIRECTED GOODS AND SERVICES ☐ SUPPORT BROKERAGE

☐ ASSISTIVE TECHNOLOGY – ADAPTIVE DEVICES ☐ COMMUNITY HABILITATION ☐ ENVIRONMENTAL MODIFICATIONS

☐ FAMILY EDUCATION & TRAINING ☐ INTENSIVE BEHAVIORAL SERVICES ☐ PATHWAY TO EMPLOYMENT

☐ VEHICLE MODIFICATIONS ☐CARE COORDINATION SERVICES ☐ CRISIS SERVICES FOR INDIVIDUALS WITH INTELLECTUAL/DEVELOPMENTAL DISABILITIES

☐ ARTICLE 16 CLINIC

7c. IS ANYONE RESIDING IN YOUR HOME RECEIVING PAYMENT TO PROVIDE CARE TO THE INDIVIDUAL RECEIVING SERVICES?

YES ☐ NO ☐

8. LIST ALL REIMBURSEMENT APPLIED FOR AND/OR RECEIVED THIS CONTRACT YEAR: (add a page if needed): This information **MUST** be reported. Please be advised that $3,000 is the maximum total amount that may be reimbursed. 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.

AGENCY	DATE	AMOUNT	APPROVED	DENIED	PENDING

9. CHECKLIST OF REQUIRED DOCUMENTS: (Please attach to this application)

☐ **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**

☐ **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.**

☐ **If enrolled with a CCO, a copy of the most recent life plan with FSS family reimbursement properly documented.**

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.

In the event that a claim for goods or services is discovered to be fraudulent, the agency to which that reimbursement application was submitted is to be notified (if not the discovering entity) and will investigate the request in question and all documentation provided with the reimbursement request. In the event that the fraudulent claim is confirmed, the individual/family will be required to pay the amount reimbursed back to the agency (if the service/good was already reimbursed) and will be suspended from any future reimbursement for goods and services for a period of time determined by the agency and OPWDD. The recipient of the reimbursement may also be subject to legal actions as determined by the agency and OPWDD.

Families may submit requests for Reimbursement to the RO or a FSS Reimbursement provider agency at any time, depending upon which entity administers the reimbursement program in that region, using the form provided by the Family Reimbursement provider agency or obtained from the individual's Care Manager or Care Coordinator. Funds are available only on a contract year basis. Any authorized, but unused, reimbursements may not be carried over by a receiving family from one year to the next. For self-directing individuals, verification is made to ensure that the FSS program is included in the current budget. Inclusion of funding in the budget does not guarantee that the request will be approved. Reimbursement requests must be consistent with FSS guidelines. Applications may be submitted to any of the Family Reimbursement Program providers by individuals, families, case managers or advocates. Anything submitted more than 90 days after purchase/occurrence will be awarded per the discretion of the Reimbursement Program provider. Applications that are not filled out in full will be returned, and payment will be delayed.

***I HAVE READ THE STATEMENT ABOVE AND UNDERSTAND THAT INFORMATION RELATED TO MY REQUEST FOR REIMBURSEMENT MAY BE MUTUALLY SHARED WITH AND/OR RECEIVED FROM OTHER AGENCIES WITHIN THE OPWDD REGION/DISTRICT:**

11. Print Name of Parent/Guardian signing form:	11a. Date Completed:
11b. **Parent/Guardian Signature**: ____ * SIGNED APPLICATION MUST BE SUBMITTED	
12. If Submitted By Care Coordinator, Print Name:	12a. Name of Care Coordination Organization (CCO):
13. Date Submitted:	

OPWDD FAMILY REIMBURSEMENT
RESPITE VERIFICATION FORM

* This form must be signed by the respite provider and the parent/family member where indicated to be considered for reimbursement. **PLEASE COMPLETE ALL AREAS IN FULL FOR FORM TO BE ACCCEPTED**

* If respite provider is a family member, he/she must maintain a residence **outside of the individual's home.**

1 NAME OF INDIVIDUAL RECEIVING SERVICES

1a DATE OF BIRTH	1b TABS NO.

2. NAME OF PARENT/GUARDIAN

2a ADDRESS	2b TELEPHONE AND EMAIL
3. RESPITE PROVIDER:	3a. RELATIONSHIP:
3b. RESPITE PROVIDER'S ADDRESS	3c. RESPITE PROVIDER'S TELEPHONE AND EMAIL

4. Does this respite provider also work for an agency to provide HCBS Waiver In-Home Hourly Respite for your child?
Yes ☐ No ☐

* If so, please note that Family Reimbursement cannot be used to supplement the hourly respite rate of pay and therefore the hours cannot be duplicated.

Date Service Provided mm/dd/yy	Time In	Time Out	Number of Hours	Rate Paid Per Hour	Total Amount Paid Per Day	**Provider's Initials**

Total Hours (this page): Total amount of Request for Reimbursement (this page):

PLEASE SEE NEXT PAGE FOR REQUIRED SIGNATURES AND INFORMATION

Agencies will conduct random spot checks for respite applications; respite providers may be contacted to verify hours and payment.

In the event that a claim for goods or services is discovered to be fraudulent, the agency to which that reimbursement application was submitted is to be notified (if not the discovering entity) and will investigate the request in question and all documentation provided with the reimbursement request. In the event that the fraudulent claim is confirmed, the individual/family will be required to pay the amount reimbursed back to the agency (if the service/good was already reimbursed) and will be suspended from any future reimbursement for goods and services for a period of time determined by the agency and OPWDD. The recipient of the reimbursement may also be subject to legal actions as determined by the agency and OPWDD.

Families may submit requests for Reimbursement to the RO or a FSS Reimbursement provider agency at any time, depending upon which entity administers the reimbursement program in that region, using the form provided by the Family Reimbursement provider agency or obtained from the individual's Care Manager or Care Coordinator. Funds are available only on a contract year basis. Any authorized, but unused, reimbursements may not be carried over by a receiving family from one year to the next. For self-directing individuals, verification is made to ensure that the FSS program is included in the current budget. Inclusion of funding in the budget does not guarantee that the request will be approved. Reimbursement requests must be consistent with FSS guidelines. Applications may be submitted to any of the Family Reimbursement Program providers by individuals, families, case managers or advocates. Anything submitted more than 90 days after purchase/occurrence will be awarded per the discretion of the Reimbursement Program provider. Applications that are not filled out in full will be returned, and payment will be delayed.

I HAVE READ THE STATEMENT ABOVE AND CERTIFY THAT THE INFORMATION PROVIDED ON THIS FORM IS ACCURATE.

Respite Providers Signature:	Date Completed:
Parent/Guardian Signature:	Date Completed:

NEW YORK STATE INSTITUTE ON DISABILITY, INC. (NYSID)
930 Willowbrook Road, Bldg. 41-A
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Emails: info@nysidinc.org or salton@nysidinc.org

Name of Applicant ______________________________ Date of Birth ______________

Home Address ______________________________Apt #_______ Borough___________ Zip ____________

Social Security # ____________________ Medicaid # ____________________ TABS ID________________

Diagnosis ____ OPWDD Eligibility: Yes: No:

Parent's Full Name____ Email_________________________

Home Phone #/Cell Phone #____

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 (WITHIN ONE YEAR) OR NOTICE OF DECISION OF OPWDD ELIGIBILITY

1. **SPORTS & ENTERTAINMENT TICKETS** (4 tickets per family)
   ____
   Attach your prioritized list: please choose up to four venues

2. **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.

3. **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 __________________

4. Reimbursement Request for Individuals in Housing Subsidy Program______________________________

   Amount Requested: ____________________________

   Check to be written to: __________________________

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 No

If yes, your application will not be accepted, as we do not provide sports and recreation tickets or transportation services for individuals with self-direction services.

Who is completing the application? Please circle below:

Parent Self Advocate Care Manager Family Member/ Representative/Other ____________________
(Specify)

Signature of Person Completing Application:

____ **Date**________________________

Revised 7/1/24

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/2023/05/attachment-a-family-reimbursement-application_3-27-23.pdf
2. PRINT OR WRITE LEGIBLY
3. Answer every applicable question. Failure to do so may result in your application being RETURNED or DENIED

3A. Answer the Self Direction Question YES or NO -If yes, your application will not be accepted, we do not provide sports and recreation tickets or transportation services for individuals with self-direction services.

4. SIGN and DATE the application
5. Incomplete applications will be returned
6. REQUIRED DATA on all applications:
    - You may submit a current Level of Care Eligibility (WITHIN ONE YEAR) Determination; or Notice of Decision for OPWDD Eligibility
    - 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)
7. 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.
8. WE WILL ACCEPT EMAILED or mail the application to the NYSID office in Staten Island
9. All applications are subject to approval, service/reimbursement is not guaranteed.
10. Applications requesting an evaluation must have a copy of an IEP, OPWDD request or a letter from a doctor requesting the evaluation.

New York State Institute on Disability, Inc. (NYSID)
930 Willowbrook Road, Bldg. 41-A
Staten Island, NY 10314
Phone: 718- 494-6457/Fax: 718-494-6461
Email: info@nysidinc.org

PROCEDURES TO REQUEST TRANSPORTATION

Car Service is available for families who have children and adults with developmental disabilities living at home in **Brooklyn, Staten Island and the Bronx.** This service is for emergency respite, camp, recreation or special medical appointments only.

For families living in **Queens** with children and adults, car service is **only available to and from recreational venues in which the individual received tickets from NYSID.**

IMPORTANT – PASSENGER MUST ALWAYS BE ACCOMPANIED BY A RESPONSIBLE ADULT

- Submit your completed NYSID application, a current LOC and/or a full psychological evaluation along with the Car Service Request Form to NYSID's Transportation Coordinator John P. O'Grady:
  Cell Phone **917-747-9424 / Email: jogrady@nysidinc.org**
- He will notify you of your eligibility and will arrange the trip.
- Please complete the "Transportation Request Form and be sure to provide the following information:
  1. Your **family name, address, and telephone number**
  2. Your **child's name and TAB Number**
  3. **Name of family member** or support person **accompanying** passenger
  4. **Reason for trip** request
  5. **Date and time of pick-up**
  6. **Destination**
  7. If **wheelchair**: **manual, fold-up, or motorized**
  8. If **round trip, time of return** pick-up
- **If you need to CANCEL or CHANGE your reservation, call the Transportation Coordinator IMMEDIATELY.**
- If your car is late or you have any other complaint, contact the Transportation Coordinator.

Please remember – a family member or support person must accompany passenger. This is a **free** service for persons who cannot otherwise obtain transportation. No money changes hands. There is NO Tipping required.

Have a safe trip!

New York State Institute on Disability, Inc. (NYSID)
930 Willowbrook Road, Bldg. 41-A
Staten Island, NY 10314
Transportation Coordinator John P. O'Grady
Cell Phone **917-747-9424 / Email: jogrady@nysidinc.org**

Car Service Request Form

Borough: ______________________ Date ______________

Agency: ____

Contact: ______________________________ Phone: ______________

TAB #:	Purpose:		
Clients Name:		Parent:	
Is the Client in a Wheel Chair?		If YES, does it fold?	
Total passengers:		Pickup Address:	
Phone Number:			
Date of Pick-Up:		Time of Pick-Up:	
Drop-off Location:			

Is this a round trip?	If Yes		
Date of Pick-Up:		Time of Pick-Up:	
Phone Number:			
Location (if different from prior Drop-off)			

Car Service: ______________________ Date Reserved: ____________________

Part I	
Conf. #	
Invoice #	
Car #	
Flat Rate	
Tips	
Tolls	
Stop	
W.T.	
SVC Chg.	
NYS Sur.	
Total:	

Part II	
Conf. #	
Invoice #	
Car #	
Flat Rate	
Tips	
Tolls	
Stop	
W.T.	
SVC Chg.	
NYS Sur.	
Total:	

Revised 07/01/24

New York State Institute on Disability, Inc.

Invites families from

Brooklyn, Bronx, Queens and Staten Island to enjoy

FAMILY OUTINGS and ENTERTAINMENT EVENTS

Children and adults with developmental disabilities who live with their families and have OPWDD Eligibility may apply for a variety of events throughout New York City

YOU MAY REQUEST UP TO FOUR (4) TICKETS PER FAMILY FOR AN EVENT
***Transportation available upon request**

Please submit an application along with a current Level of Care Eligibility Determination or Psychological Evaluation with your top ***four choices*** *of the following venues:*

__ American Museum of Natural History
__Bronx Zoo
__Brooklyn Aquarium
__Central Park Zoo
__Intrepid Sea, Air & Space Museum
__Land of Fun (Brooklyn)
__Madame Tussaud's Wax Museum
__Movie Tickets
__New York Botanical Garden
__New York Hall of Science
__Prospect Park Zoo
__Queens Zoo
__Staten Island Children's Museum
__ Staten Island Zoo (Spooktacular)
__Brooklyn Nets (Oct-April)
__Brooklyn Cyclones (June-Sept)
__Wrestling (July and December)

__Tickets for Shows and Events at the New Victory Theater, Circus, Dave n Busters and other Venues

****

APPLICATIONS ARE PROCESSED ON A FIRST COME, FIRST SERVE BASIS

PRIORITY WILL BE GIVEN TO FAMILIES NOT PREVIOUSLY SERVED

WE DO NOT PROVIDE TICKETS FOR INDIVIDUALS WITH SELF-DIRECTION SERVICES

TICKETS ARE SUBJECT TO AVAILABILITY AND FUNDING

For more information and an application please contact

Sarah Alton - Office Phone: 718-494-6457- Email: salton@nysidinc.org

New York State Institute on Disability, Inc.
930 Willowbrook Road, Building 41-A
Staten Island, NY 10314

Revised 7/1/24

New York State Institute on Disability, Inc.

REIMBURSEMENT REQUEST FORM

2024/2025 Fiscal Year

NYSID WILL ACCEPT EMAILED APPLICATIONS

INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED

THIS FORM MUST ACCOMPANY ALL REIMBURSEMENT REQUESTS SUBMITTED TO NYSID

You must answer ALL these questions when submitting your reimbursement request:

Individuals Name____

Tabs ID _______________ **County of Residence** _________________________

1. **Is the individual enrolled in Medicaid?** **Yes** _____ **No** _____
2. **Is the individual enrolled in Medicaid Waiver?** **Yes** _____ **No** _____
3. **Does the individual reside at home with their family?** **Yes** _____ **No** _____
4. **Is the individual enrolled in Self-Direction Services?** **Yes:** ___ **No:** ___ **Pending Budget Approval:** ___
5. **Does this item support the individual remaining at home with their family/caregiver?** **Yes:** ___ **No:**___
6. **Is the request for the item/items** **One time only:** ______ **Ongoing:** ______

   6a. If ongoing, please indicate frequency______________________________

7. **Please provide a website link for the item. (If applicable)**

   ____

The State is allowing up to $3,000 per fiscal year which is inclusive of camp, goods and services such as clothing, recreation programs, and sensory items etc.

FSS Reimbursement Allowable and Non-Allowable Items

https://opwdd.ny.gov/system/files/documents/2024/06/fss-reimbursement-allowable-and-non-allowable-items_-revised_6.10.24-002.pdf

OPWDD FSS Reimbursement Request FAQ's

https://opwdd.ny.gov/system/files/documents/2024/06/fss-family-reimbursement-adm-faq_6.10.24.pdf

OPWDD Administrative Memorandum Guidelines for FSS Reimbursement Requests

https://opwdd.ny.gov/regulations-guidance/adm-2022-02-family-support-services-fss-reimbursement-guidelines -

* It would be advisable for a family to work with only one agency through the fiscal year for applications to be processed in a timely manner. *Applying to multiple agencies delays the processing of an application.*

If you have any questions or need more information, please call New York State Institute on Disability at 929-202-1115 / 718-494-6457or email info@nysidinc.org.

New York State Institute on Disability, Inc.
REIMBURSEMENT APPLICATION CHECKLIST
2024/2025 Fiscal Year

APPLICATIONS FOR CAMP REIMBURSEMENT

**** IF AN INDIVIDUAL IS ATTENDING A CAMP THAT BILLS FOR WAIVER/RESPITE, THEY WILL NOT BE ELIGIBLE TO RECEIVE FAMILY SUPPORT REIMBURSEMENT FOR THE BALANCE DUE TO THE CAMP. THIS WILL BE THE PARENTS' RESPONSIBILITY.***

****IF AN INDIVIDUAL HAS SELF-DIRECTION SERVICES, THEY ARE EXPECTED TO PAY FOR CAMP THROUGH THEIR BUDGET AND NOT WITH FAMILY SUPPORT SERVICES FUNDS.***

NYSID WILL ACCEPT EMAILED APPLICATIONS

INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED

ALL reimbursement application packets must include the following information.

____ NYSID Reimbursement Request Form – All Questions must be Answered

____ OPWDD updated application has been submitted https://opwdd.ny.gov/system/files/documents/2023/05/attachment-a-family-reimbursement-application_3-27-23.pdf -Application Link
*** A family member/care manager must submit the new Fully Completed State Application**

___ **Application Form must have ALL questions answered**, ***if you answer YES to question 7c_application will not be accepted; individual is not eligible for FSS reimbursement if a household member receives payment to care for the individual.***

____ *Justification letter* **** Camp applications do not require clinical justification; however, a justification letter is required explaining why the individual attends camp***

____ Individual's Finalized Life Plan submitted. *** An individual's Life Plan must accompany the application. Life plan must also include the "why" the individual needs the item and "how" it is related to the individual's disability in section 1 summary and in section 5 must the life plan must include NYSID as the family support services provider (if it does not include our agency we would not be able to serve the individual).**

____ NYS Department of Health Certificate **** All camp applications must have a current department of health certificate that matches the name of the camp on the invoice/bill.***

____ Camp Invoice/Paid Receipt ****Camp invoice must include the individual's name, dates of attendance; cost of camp, amount paid or balance due. We can pay for the camp directly and will require proof of attendance by the end of the summer. *If proof of attendance is not submitted the family /camp will be expected to refund this agency for any funds provided.*** *We can only pay up to 14 days of overnight camp attendance. *We can pay for more than 14 days for day camp attendance.

____ Letter of Attestation from the camp confirming they do not bill for waiver respite for the individual.

New York State Institute on Disability, Inc.

REIMBURSEMENT APPLICATION CHECKLIST FOR GOODS AND SERVICES
2024/2025 Fiscal Year

NYSID WILL ACCEPT EMAILED APPLICATIONS
INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED

ALL reimbursement application packets must include the following information.

____ NYSID Reimbursement Request Form – **Must have all questions answered**

____ OPWDD updated application has been submitted https://opwdd.ny.gov/system/files/documents/2023/05/attachment-a-family-reimbursement-application_3-27-23.pdf -Application Link
.

____ **Application Form must have ALL questions answered*, if you answer YES to question 7c_application will not be accepted; individual is not eligible for FSS reimbursement if a household member receives payment to care for the individual*.**

____ **Included in section 8 ALL previous reimbursement applications within this fiscal year, when multiple applications are submitted.**

____ Clinical Justification * **A clinical justification letter is required for clothing / sensory items, (supplements, mattresses, eyeglasses will need insurance denial) the letter MUST relate to the individual's disability and explain WHY they are needed. The letter must be dated, on letterhead, signed (an electronic signature is acceptable), and include the clinicians license number.**

____ Individual's **Finalized** Life Plan submitted. * **An individual's Life Plan must accompany the application. Life plan must also include the "why" the individual needs the item and "how" it is related to the individual's disability in section 1 summary; if the need is due to a behavior there must be a "plan of action" on how the behavior is being addressed and in section 5 must the life plan must include NYSID as the family support services provider (if it does not include our agency we would not be able to serve the individual).**

____ Individuals Notice of Decision from of OPWDD that reflects that the individual has OPWDD Eligibility. If the individual does not have a Life Plan**.**

____ Detailed Invoice/Receipts submitted. * **The receipts submitted must be within the fiscal year AND within 90 days of purchase. We do not accept screen shots of receipts. Recreational (swimming, music lessons, horseback riding etc.) receipts must include the individual's name, the dates the lessons were taken (we will not pay for lessons not yet taken), frequency of the lessons (weekly, monthly, etc..) with the cost of each lesson and payment method.**

____ Respite Reimbursement requests must have a completed OPWDD Respite Verification Form https://opwdd.ny.gov/system/files/documents/2022/06/attachment-b-respite-verification-form.pdf Family must also provide receipts from the respite provider that confirms the payment amount they received. The receipt must be signed and dated.

____ Individual's With a Self- Direction Budget must include NYSID as Family Support Services Provider ***If the individual has self-direction services, they must provide a copy of the approved budget that includes the agency provider, dated of approved budget and amount approved for FSS.**

NEW YORK STATE INSTITUTE ON DISABILITY, INC. (NYSID)
930 Willowbrook Road, Bldg. 41-A
Staten Island, NY 10314
Phone 718 494-6457
Cell 929-202-1115
Email: info@nysidinc.org

SERVICES PROVIDED BY NYSID

- Free in-home evaluations to individuals that **DO NOT** have Medicaid for the purposes of obtaining OPWDD Eligibility for individuals residing in Queens, Brooklyn, Bronx and Staten Island. You may contact Elizabeth Sunshine at 917-699-0578 or email esunshine@nysidinc.org for additional information.

- Crisis Management Services to families in The Bronx, Brooklyn and Queens you may contact Juliet Hawkins at 917-524-4856 or email jhawkins@nysidinc.org for additional information

- Reimbursement for goods, services and camp to individuals that reside in the five boroughs. You may contact Jackie Tripodi at 929-202-1115 or email jtripodi@nysidinc.org for additional information.

- Recreation outings for individuals residing in the Bronx, Brooklyn, Queens and Staten Island. We **do not** provide recreation outings to individuals with self-direction services or reside in Manhattan. You may contact Sarah Alton at 718-494-6457 or email salton@nysidinc.org for additional information.

- Transportation services in Brooklyn, Bronx and Staten Island for medical appointments or recreation activities for an individual and members of their family. In Queens we can provide transportation to an individual attending a venue we provide tickets for. We **do not** provide transportation to individuals with self-direction services or reside in Manhattan. An individual is able to receive up to 4 transportation trips per fiscal year. You may contact John O'Grady our transportation coordinator at 917-747-9424 or email jogrady@nysidinc.org for additional information.

These services are all provided through family support contracts and can only be provided to individuals that reside home with their families and have OPWDD Eligibility (or are seeking an evaluation to obtain eligibility).

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930 Willowbrook Road, Bldg. 41-A
Staten Island, NY 10314
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PROCEDURES TO REQUEST TRANSPORTATION

Car Service is available for families who have children and adults with developmental disabilities living at home in **Brooklyn, Staten Island and the Bronx.** This service is for emergency respite, camp, recreation or special medical appointments only.

For families living in **Queens** with children and adults, car service is **only available to and from recreational venues in which the individual received tickets from NYSID.**

IMPORTANT – PASSENGER MUST ALWAYS BE ACCOMPANIED BY A RESPONSIBLE ADULT

- Submit your completed NYSID application, a current LOC and/or a full psychological evaluation along with the Car Service Request Form to NYSID's Transportation Coordinator John P. O'Grady:
  Cell Phone **917-747-9424 / Email: jogrady@nysidinc.org**
- He will notify you of your eligibility and will arrange the trip.
- Please complete the "Transportation Request Form and be sure to provide the following information:
  1. Your **family name, address, and telephone number**
  2. Your **child's name and TAB Number**
  3. **Name of family member** or support person **accompanying** passenger
  4. **Reason for trip** request
  5. **Date and time of pick-up**
  6. **Destination**
  7. If **wheelchair**: **manual, fold-up, or motorized**
  8. If **round trip, time of return** pick-up
- **If you need to CANCEL or CHANGE your reservation, call the Transportation Coordinator IMMEDIATELY.**
- If your car is late or you have any other complaint, contact the Transportation Coordinator.

Please remember – a family member or support person must accompany passenger. This is a **free** service for persons who cannot otherwise obtain transportation. No money changes hands. There is NO Tipping required.

Have a safe trip!

Revised 07/01/24

New York State Institute on Disability, Inc. (NYSID)
930 Willowbrook Road, Bldg. 41-A
Staten Island, NY 10314
Transportation Coordinator John P. O'Grady
Cell Phone **917-747-9424 / Email: jogrady@nysidinc.org**

Car Service Request Form

Borough: ______________________ Date ______________

Agency: ____

Contact: __________________________ Phone: ______________

TAB #:	Purpose:		
Clients Name:		Parent:	
Is the Client in a Wheel Chair?		If YES, does it fold?	
Total passengers:		Pickup Address:	
Phone Number:			
Date of Pick-Up:		Time of Pick-Up:	
Drop-off Location:			

Is this a round trip?	If Yes		
Date of Pick-Up:		Time of Pick-Up:	
Phone Number:			
Location (if different from prior Drop-off)			

Car Service: ______________________ Date Reserved: ____________________

Part I	
Conf. #	

Invoice #	
Car #	
Flat Rate	
Tips	
Tolls	
Stop	
W.T.	
SVC Chg.	
NYS Sur.	
Total:	

Part II	
Conf. #	

Invoice #	
Car #	
Flat Rate	
Tips	
Tolls	
Stop	
W.T.	
SVC Chg.	
NYS Sur.	
Total:	

Revised 07/01/24

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
Emails: info@nysidinc.org or salton@nysidinc.org

Name of Applicant ________________________________ Date of Birth ______________

Home Address ______________________________ Apt #______ Borough__________ Zip ___________

Social Security # __________________ Medicaid # __________________ TABS ID_______________

Diagnosis ____ OPWDD Eligibility: Yes: No:

Parent's Full Name_____________________________________ Email_______________________

Home Phone #/Cell Phone #____

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 (WITHIN ONE YEAR) OR NOTICE OF DECISION OF OPWDD ELIGIBILITY

1. **SPORTS & ENTERTAINMENT TICKETS** (4 tickets per family)
   ____
   Attach your prioritized list: please choose up to four venues

2. **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.

3. **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 _________________

4. Reimbursement Request for Individuals in Housing Subsidy Program___________________________

   Amount Requested: ___________________________

   Check to be written to: __________________________

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 No

If yes, your application will not be accepted, as we do not provide sports and recreation tickets or transportation services for individuals with self-direction services.

Who is completing the application? Please circle below:

Parent Self Advocate Care Manager Family Member/ Representative/Other _________________
(Specify)

Signature of Person Completing Application:

____ **Date**____________________

Revised 7/1/24

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/2023/05/attachment-a-family-reimbursement-application_3-27-23.pdf
2. PRINT OR WRITE LEGIBLY
3. Answer every applicable question. Failure to do so may result in your application being RETURNED or DENIED

3A. Answer the Self Direction Question YES or NO -If yes, your application will not be accepted, we do not provide sports and recreation tickets or transportation services for individuals with self-direction services.

4. SIGN and DATE the application
5. Incomplete applications will be returned
6. REQUIRED DATA on all applications:
    - You may submit a current Level of Care Eligibility (WITHIN ONE YEAR) Determination; or Notice of Decision for OPWDD Eligibility
    - 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)
7. 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.
8. WE WILL ACCEPT EMAILED or mail the application to the NYSID office in Staten Island
9. All applications are subject to approval, service/reimbursement is not guaranteed.
10. Applications requesting an evaluation must have a copy of an IEP, OPWDD request or a letter from a doctor requesting the evaluation.

OPWDD FAMILY REIMBURSEMENT
RESPITE VERIFICATION FORM

* This form must be signed by the respite provider and the parent/family member where indicated to be considered for reimbursement. **PLEASE COMPLETE ALL AREAS IN FULL FOR FORM TO BE ACCCEPTED**
* If respite provider is a family member, he/she must maintain a residence **outside of the individual's home.**

1 NAME OF INDIVIDUAL RECEIVING SERVICES

1a DATE OF BIRTH	1b TABS NO.

2. NAME OF PARENT/GUARDIAN

2a ADDRESS	2b TELEPHONE AND EMAIL
3. RESPITE PROVIDER:	3a. RELATIONSHIP:
3b. RESPITE PROVIDER'S ADDRESS	3c. RESPITE PROVIDER'S TELEPHONE AND EMAIL

4. Does this respite provider also work for an agency to provide HCBS Waiver In-Home Hourly Respite for your child?
Yes ☐ No ☐

* If so, please note that Family Reimbursement cannot be used to supplement the hourly respite rate of pay and therefore the hours cannot be duplicated.

Date Service Provided mm/dd/yy	Time In	Time Out	Number of Hours	Rate Paid Per Hour	Total Amount Paid Per Day	**Provider's Initials**

Total Hours (this page): Total amount of Request for Reimbursement (this page):

PLEASE SEE NEXT PAGE FOR REQUIRED SIGNATURES AND INFORMATION

Agencies will conduct random spot checks for respite applications; respite providers may be contacted to verify hours and payment.

In the event that a claim for goods or services is discovered to be fraudulent, the agency to which that reimbursement application was submitted is to be notified (if not the discovering entity) and will investigate the request in question and all documentation provided with the reimbursement request. In the event that the fraudulent claim is confirmed, the individual/family will be required to pay the amount reimbursed back to the agency (if the service/good was already reimbursed) and will be suspended from any future reimbursement for goods and services for a period of time determined by the agency and OPWDD. The recipient of the reimbursement may also be subject to legal actions as determined by the agency and OPWDD.

Families may submit requests for Reimbursement to the RO or a FSS Reimbursement provider agency at any time, depending upon which entity administers the reimbursement program in that region, using the form provided by the Family Reimbursement provider agency or obtained from the individual's Care Manager or Care Coordinator. Funds are available only on a contract year basis. Any authorized, but unused, reimbursements may not be carried over by a receiving family from one year to the next. For self-directing individuals, verification is made to ensure that the FSS program is included in the current budget. Inclusion of funding in the budget does not guarantee that the request will be approved. Reimbursement requests must be consistent with FSS guidelines. Applications may be submitted to any of the Family Reimbursement Program providers by individuals, families, case managers or advocates. Anything submitted more than 90 days after purchase/occurrence will be awarded per the discretion of the Reimbursement Program provider. Applications that are not filled out in full will be returned, and payment will be delayed.

I HAVE READ THE STATEMENT ABOVE AND CERTIFY THAT THE INFORMATION PROVIDED ON THIS FORM IS ACCURATE.

Respite Providers Signature:	Date Completed:
Parent/Guardian Signature:	Date Completed:

OPWDD FSS FAMILY REIMBURSEMENT APPLICATION

Application must be filled out completely in order to be considered

1. NAME OF INDIVIDUAL RECEIVING SERVICES:

1a DATE OF BIRTH:	1b. TABS NO.:

1c. ADDRESS (Street/Town/Zip):

1d. COUNTY:	1e. NUMBER OF PEOPLE IN THE HOME:

2. NAME OF PARENT / RELATIVE / GUARDIAN:

2a. PARENT / GUARDIAN EMAIL:	2b. PARENT / GUARDIAN PHONE #:
3. CARE MANAGER'S NAME:	3a. CARE MANAGER'S ADDRESS (Street/City/Zip):
3b. CARE MANAGER'S EMAIL:	3c. CARE MANAGER'S PHONE #:

4. FISCAL INTERMEDIARY (If Applicable- Name/Agency/Phone/Email):

5. DIAGNOSIS – PLEASE CHECK ALL THAT APPLY PER OPWDD

☐ Intellectual Disability ☐ Traumatic Brain Injury – TBI ☐ Other

☐ Autism ☐ Cerebral Palsy

☐ Epilepsy (seizures) ☐ Neurological Impairment

6. WHAT IS THE ITEM (S) OR SERVICE REQUESTED FOR REIMBURSEMENT – PLEASE DESCRIBE:

Please note - camp can only be reimbursed if the camp has a permit by the New York State Department of Health and/or Local Department of Health pursuant to Subpart 7 of the New York State Sanitary Code (see 10 NYCRR Subpart 7).

TOTAL AMOUNT REQUESTED ON THIS APPLICATION:

* IS THIS ITEM/SERVICE AN IMMEDIATE CRISIS SITUATION AS IDENTIFIED IN THE GUIDELINES? Please check one:

YES ☐ NO ☐

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.

YES ☐ NO ☐ **RESULTS**

7a. IS THE INDIVIDUAL ENROLLED IN MEDICAID? YES ☐ NO ☐

7b. WHAT SERVICES ARE YOU RECEIVING EITHER THROUGH THE HOME AND COMMUNITY BASED (HCBS) WAIVER AND/OR OPWDD STATE PLAN SERVICES?

☐ RESPITE ☐ DAY HABILITATION ☐ LIVE-IN CAREGIVER ☐ PREVOCATIONAL SERVICES

☐ RESIDENTIAL HABILITATION ☐ SUPPORTED EMPLOYMENT ☐ COMMUNITY TRANSITION SERVICES

☐ FISCAL INTERMEDIARY ☐ INDIVIDUAL DIRECTED GOODS AND SERVICES ☐ SUPPORT BROKERAGE

☐ ASSISTIVE TECHNOLOGY – ADAPTIVE DEVICES ☐ COMMUNITY HABILITATION ☐ ENVIRONMENTAL MODIFICATIONS

☐ FAMILY EDUCATION & TRAINING ☐ INTENSIVE BEHAVIORAL SERVICES ☐ PATHWAY TO EMPLOYMENT

☐ VEHICLE MODIFICATIONS ☐CARE COORDINATION SERVICES ☐ CRISIS SERVICES FOR INDIVIDUALS WITH INTELLECTUAL/DEVELOPMENTAL DISABILITIES

☐ ARTICLE 16 CLINIC

7c. IS ANYONE RESIDING IN YOUR HOME RECEIVING PAYMENT TO PROVIDE CARE TO THE INDIVIDUAL RECEIVING SERVICES?

YES ☐ NO ☐

8. LIST ALL REIMBURSEMENT APPLIED FOR AND/OR RECEIVED THIS CONTRACT YEAR: (add a page if needed): This information **MUST** be reported. Please be advised that $3,000 is the maximum total amount that may be reimbursed. 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.

AGENCY	DATE	AMOUNT	APPROVED	DENIED	PENDING

9. CHECKLIST OF REQUIRED DOCUMENTS: (Please attach to this application)

☐ **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**

☐ **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.**

☐ **If enrolled with a CCO, a copy of the most recent life plan with FSS family reimbursement properly documented.**

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.

In the event that a claim for goods or services is discovered to be fraudulent, the agency to which that reimbursement application was submitted is to be notified (if not the discovering entity) and will investigate the request in question and all documentation provided with the reimbursement request. In the event that the fraudulent claim is confirmed, the individual/family will be required to pay the amount reimbursed back to the agency (if the service/good was already reimbursed) and will be suspended from any future reimbursement for goods and services for a period of time determined by the agency and OPWDD. The recipient of the reimbursement may also be subject to legal actions as determined by the agency and OPWDD.

Families may submit requests for Reimbursement to the RO or a FSS Reimbursement provider agency at any time, depending upon which entity administers the reimbursement program in that region, using the form provided by the Family Reimbursement provider agency or obtained from the individual's Care Manager or Care Coordinator. Funds are available only on a contract year basis. Any authorized, but unused, reimbursements may not be carried over by a receiving family from one year to the next. For self-directing individuals, verification is made to ensure that the FSS program is included in the current budget. Inclusion of funding in the budget does not guarantee that the request will be approved. Reimbursement requests must be consistent with FSS guidelines. Applications may be submitted to any of the Family Reimbursement Program providers by individuals, families, case managers or advocates. Anything submitted more than 90 days after purchase/occurrence will be awarded per the discretion of the Reimbursement Program provider. Applications that are not filled out in full will be returned, and payment will be delayed.

***I HAVE READ THE STATEMENT ABOVE AND UNDERSTAND THAT INFORMATION RELATED TO MY REQUEST FOR REIMBURSEMENT MAY BE MUTUALLY SHARED WITH AND/OR RECEIVED FROM OTHER AGENCIES WITHIN THE OPWDD REGION/DISTRICT:**

11. Print Name of Parent/Guardian signing form:	11a. Date Completed:
11b. **Parent/Guardian Signature**: ____ * SIGNED APPLICATION MUST BE SUBMITTED	
12. If Submitted By Care Coordinator, Print Name:	12a. Name of Care Coordination Organization (CCO):
13. Date Submitted:	

03/2023

Office for People With Developmental Disabilities

Family Support Services Family Reimbursement
Allowable and Non-Allowable Items
Updated 6/10/24

Allowable Items:

- Recreation Activity/Program/Equipment
  - Integrated, community-based activity fees/supplies
  - Instrumental and music lessons/fees (e.g., guitar lessons, piano lessons)
  - Braille bingo cards, playing cards and dominoes
  - Cooking classes (not resulting in certification)
  - Theatre classes/workshops
  - Museum membership (e.g., sensory, STEM)
  - Art classes
  - Gym membership
  - Fitness classes
  - Swim lessons
  - Sports lessons/fees/expenses (e.g., Soccer, Baseball, Golf, Skiing, Bowling, Cheerleading)
  - Martial Arts lessons (e.g. Karate, Tae kwon do)
- Recreation Activity/Program Equipment, continued
  - Dance/ballet lessons
  - Equine therapy/Hippo therapy/Horseback riding
- Sensory Items
  - Balance chair
  - Bean bag chair
  - Indoor or outdoor swing
  - Mini trampoline (single user)
  - Climber
  - Fidget items/sensory toys
  - Shower head
  - Positioning cushion/wedge
  - Floor mats
  - Noise cancelling ear coverings
  - Therapy tunnel
  - Sensory Activities/crafts, as related to I/DD diagnosis

- Items/Services that are not covered or available through other means and are reviewed and approved by the Committee
- Respite (see section G of the ADM)
- Camp (see section H of the ADM)
- Electronic devices (see section J of the ADM)
- Supplements/Over-the-counter medications approved by a clinician if denied by insurance* and outlined in the individual's treatment plan as related to I/DD diagnosis
- Replacement/repair of prescription eyeglasses or hearing aids if denied by insurance*
- Legal fees related to guardianship and special needs trusts
- Clothing as a necessity due to atypical needs to include:
  - Specific clinical needs related to the intellectual/developmental disability (I/DD) (e.g., excessive chewing, destruction due to behavior or incontinence). Clinical need should be included in the Life Plan (if applicable) with a plan to mitigate the behavior (as applicable), or other appropriate documentation requested by the FSS provider and/or Regional Field Office (RFO) to substantiate the request*, *or*
  - Health/safety, environmental or functional needs (i.e. winter jacket, snow boots, etc.),
- Incontinence related items/supplies, in the absence of Medicaid and/or Third Party Insurance to cover this, or if you exceed the quantity of the product as covered by insurance.*
- Mattress/box spring purchase/replacement as an atypical expense due to documented incontinence/behavioral issues with a plan to address such behaviors (as applicable) *or* resulting from environmental hazards (e.g., bed bugs, fire/water damage). *Requests not to exceed once every 2 years*,
- Protective mattress covers (waterproof, bedbug preventative, etc.), *and*
- Other items as deemed appropriate and reimbursable by the RFO

Non-Allowable Items:

Healthcare/Personal care:

- Items covered by Medicaid or other health insurance, including incontinence items & prescription medications/medical supplies
- Diapers if covered by insurance*
- Wipes if covered by insurance*
- Bibs
- Experimental treatments/therapies
- Dental activities
- Toothbrush
- Prescription eyeglasses if covered by insurance*
- Dermatology services
- Sedation
- Enemas
- Oral swabs, syringes
- Portable tub
- CBD or marijuana products
- Nutrisystem – weight loss program
- Personal training
- Life coach
- Exercise equipment (e.g.: elliptical machine, treadmill, free weights)

Household Expenses:

- Appliances, large and small (e.g., washing machine, dryer, blender)
- Furniture
- Mattress, *unless criteria met* *
- Home repairs*
- Rent/rental deposit*
- Maintenance items*
- Air conditioner
- Snowplow/snowplow services
- Video monitoring system
- Pool cover
- Water fountain
- Food *(as an ongoing/routine expense)**
- Bento box, water bottle

Travel/Transportation:

- Vehicles (e.g., cars, motorcycles)
- Car repairs
- Batteries (side-by-side bike, wheelchair—if covered by insurance*, etc.)
- Car fuel
- Car seat
- Hotel/lodging, mileage and travel costs
- Conference expenses
- Bicycles/Tricycles/Scooters
- Taxi service/Uber or Lyft rides
- Stroller

Fiscal Expenses:

- Real property (e.g., home or apartment related costs)*
- Finance charges
- Tax bills
- Sales tax
- Shipping fees
- Co-pays
- Fines
- Funeral expenses

Duplicative Expenses/Otherwise Covered:

- *Upgrades* to items/services covered by HCBS Waiver or other sources, including self- direction budgets (e.g., upgrading fencing materials, additional funding for a higher cost camp)
- Items/services related to/required for [Waiver based] day program participation/enrollment
- Items covered by other state paid benefits (e.g., free cell phone programs)
- Items covered by self-direction budget, *if* someone is self-directing services
- Equipment repair/replacement

<u>Non-Allowable Items, Continued:</u>

Educational Based Services/Goods:

- College courses/Certification programs
- Homeschool books
- Tutoring
- After-school programs
- Academic testing/retesting
- Items and services that an individual is eligible for in the context of their educational services (e.g., occupational therapy, physical therapy)
- ABC Mouse learning program/app

Miscellaneous Items/Services:

- Regular and ongoing subscription plans
- Cell phone purchase and cellular plans
- Data plans for iPad
- Headphones
- GPS Trackers/devices; video or audio monitoring devices
- Outdoor recreational equipment (swings, playsets)
- Typical expenses/entrance fees associated with community-based, recreational activities (e.g., zoos, theme parks)
- Luxury items (e.g., swimming pools, hot tubs)
- Concert tickets
- Clothing as a typical expense or *unless criteria met related to the person's I/DD diagnosis or health/safety need**
- Baby gates
- Other items deemed not appropriate for reimbursement by the RFO

See section I (3) of the ADM for Allowable One-Time Reimbursements of these items/services

New additions are highlighted

***Indicates proof required**