Frequently Asked Questions Regarding the OPWDD FSS Family Reimbursement ADM 2022-02R

Responses as of June 10, 2024

	Question	Response
1.	Do new applications need to be submitted for applications/pre-authorized goods/services already approved in before the ADM is effective 7/1/22?	No. As long as what was previously approved meets the requirements outlined in the ADM, the previously approved application can remain.
2.	Are providers required to accept receipts/requests for reimbursements 90 days after the contract year ends?	No. Providers aren't required to accept receipts/requests for reimbursement 90 days after the end of the year. They can choose to restrict it to less than 90 days. The 90 days was suggested to give providers enough time to close out everything from the previous year.
3.	Does the committee need to meet for an emergency reimbursement or can that just be done at the provider level?	Yes. The committee is required to meet for all types of reimbursements, including emergency reimbursement.
4.	How should providers handle the spending cap changing halfway through the contract year?	It's going to depend on the available resources of the provider to determine if they can reimburse for over $3,000 in this contract year. The provider must adhere to the priority tiers and will have to balance how much they can reimburse for with the number of people they are expected to serve within their contract work plan.
5.	Can providers set a cap lower than the statewide cap for a specific good/service? For example, $750 per individual for respite only.	Yes. The ADM does not prevent providers from setting a cap *lower* than the statewide cap for a specific good/service.
6.	Do applications and respite verification forms require original signatures or are digital/electronic signatures allowable?	Electronic/digital signatures are allowable. Please note that OPWDD has removed references to "original signatures" from the ADM and all attachments.
7.	Under Section B: Eligibility, it indicates that the individual must reside with a non-paid family member. What does that mean? We have parents that access CDPAP, does this mean they are disqualified?	Paid Caregivers are not eligible for Family Reimbursement. The CDPAP program allows family/caregivers to be paid as CDPAP staff while living with the person they provide CDPAP to. CDPAP also allows for someone who lives outside of the home to provide CDPAP services. Family/caregivers who provide CDPAP to a person they live with are ineligible for FSS family reimbursement. When a person receives CDPAP only from one or more staff who live outside of their home, their family is eligible to apply for FSS family reimbursement.

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Responses as of June 10, 2024

	Question	Response
8.	Can an individual receive FSS reimbursement if they have a self-direction budget and have exhausted OTPS, IDGS and/or FRR?	No. Individuals can consider accessing FSS family reimbursement if they have explored those self-direction specific funding mechanisms (i.e., OTPS, IDGS, FRR) and have been denied or as an emergency reimbursement.
9.	Does an individual need to have a care manager or be enrolled in care coordination to receive FSS family reimbursement?	No, care management is not a requirement to request FSS family reimbursement.
10.	How often are emergency reimbursement requests allowed per individual?	Emergency requests may be allowed only onetime per each type of emergency listed in the ADM.
11.	How should goods/services be treated that aren't specifically listed as allowable or non-allowable in the ADM?	Providers can continue to reimburse for goods/services they have already pre-approved if they meet the criteria outlined in the ADM. Providers must send any items that are not covered on the list in the ADM to their Regional Field Office (RFO) to Central Office for consideration before the individual is reimbursed to ensure consistency statewide.
12.	What are the requirements of the family reimbursement committee?	As noted on pg. 5 of the ADM: FSS providers must have a Family Reimbursement Committee (the "Committee") to review reimbursement requests. Committees must contain at least four (4) members, and must include: i. Individual(s) with developmental disabilities; or ii. Family members or advocates of individuals with developmental disabilities; and iii. At least two (2) people not employed by the FSS provider agency. The Committee must meet as needed to review applications. The Committee can only approve applications for reimbursements through FSS where the application establishes that the: i. Individual has established eligibility for OPWDD services; ii. Individual/family meets FSS eligibility criteria; iii. Reimbursement request cannot be funded by any other funding mechanism; iv. Reimbursement request does not exceed contractual limits and/or individual spending cap; v. Requested item or service: a. Is related to the individual's intellectual or developmental disability; b. Supports a quality of life comparable, to the extent practicable, to that of similarly situated

	Question	Response
		families without a family member having a developmental disability; c. Maximizes the potential of the individual; and d. Supports the individual to remain at home with their family.
13.	Can an individual enrolled in Self-Direction, but still in the start-up phase receive family reimbursement?	The person is only eligible for family reimbursement prior to approval of the person's initial Self-Direction budget or in circumstances as described in question 8.
14.	What are the requirements for an allowable clothing reimbursement request?	Clinical justification would be needed if the clothing request is based on behaviors or incontinence directly connected to the individual's I/DD diagnosis and needs to be included in the Life Plan if someone is enrolled in a Care Coordination Organization (CCO.) When clothing is requested as a necessity (see #21 for more information), a clinical justification would not be required.
15.	What is specifically needed for a proper clinical justification?	The family must provide the FSS provider with a clinical justification that indicates a significant, definable, positive impact on the individual/family directly relating to health, safety and emotional well-being, normalization of life, accessibility to needed services, personal growth and/or development of the individual. The clinical justification must be clinically indicated and substantiate the need for the item or service that is being requested. The clinical justification must be supported by a clinician and demonstrate a clear connection to the individual's developmental and/or intellectual disability. Clinical justification from clinician(s) working within their scope of practice including but not limited to physical therapist, occupational therapist, speech therapist, physician, registered nurse, is acceptable. The clinician must provide a signed letter dated within a year of request (on formal letterhead) that demonstrates the need based on the criteria listed above in this paragraph.
16.	When are clinical justifications required?	Clinical justifications are not required when the basis of the request is for a necessity, respite, recreations programs, camps and other items/services that are not driven by a specific clinical need. FSS providers need to obtain clinical justifications and/or physicians orders where the need for the item/service was identified as part a physician or clinician service (see the FSS ADM, Section N for more details). Clinical justification is also required for FSS reimbursement of electronic devices, as detailed in the FSS ADM, Section J., Electronic Devices. Please see question (#15) for specific information that needs to be included in the clinical

	Question	Response
		justification. For more information about clothing requests, please see question #14.
17.	Is partial reimbursement of a good or service allowable?	Per the ADM, as a state paid service, any goods or services must be cost effective meaning whenever a comparable item is available at a lesser cost, the lesser cost item must be purchased or utilized. Partial reimbursement for goods and services is at the discretion of the provider.
18.	How should individuals requesting respite reimbursement be prioritized in terms of Waiver enrollment?	Individuals enrolled in any Waiver Service must explore Waiver respite prior to accessing FSS family reimbursed respite. The individual/family with their Care Manager (CM) if applicable must explore if Waiver respite opportunities are available. If staffing is not available from any Waiver respite providers, individuals/families can then apply for FSS family reimbursed respite.
19.	How should FSS family reimbursement be documented in an individual's Life Plan?	Per the ADM, for those that have a (CM) FSS should be listed in Section V of the Life Plan. In addition, reference to the requested goods or services must be included in Section I of the Life Plan. This is needed to provide a better understanding of why the good or service is being considered for family reimbursement.
20.	Is respite allowable during the hours a parent/caregiver is working?	Routine expenses one would incur in caring for a loved one without a disability or raising a child remains the (fiscal) responsibility of the caregiver. FSS funded respite, and respite by definition, is not intended to offer ongoing, long-term coverage for care but to allow the caregiver an occasional break in routine caregiving needs. Both the regularity of this service and how frequently it is provided should be assessed by the FSS provider in terms of appropriateness and need. Respite funding should never overlap with Medicaid paid/Waiver services or educational programming (and occur outside of the regularly scheduled academic day).
21.	What does clothing as a necessity mean?	Clothing as a necessity can include specially designed garments for individuals with physical disabilities or medically prescribed clothing/articles for which other funding is not available. Per the ADM, clothing may be funded if there are specific needs related to the intellectual/developmental disability (I/DD) (e.g., excessive chewing, destruction due to behavior or incontinence) where clothing needs replacement more frequently than would otherwise be normally expected. Clothing related to the intellectual/developmental disability (I/DD) needs to be clinically indicated (i.e., included in the Life Plan or with supporting documentation). Clothing as a necessity can also include articles related to health/safety,

	Question	Response
		functional, or environmental needs. Unless sufficiently justified, it remains the responsibility of the caregiver to provide clothing and daily wardrobe needs to children and adults in their care as an out-of-pocket expense not otherwise covered.
22.	Can more than one FSS provider be listed in a Self-Direction budget?	Yes, multiple providers can be listed. There is only one field on the OPWDD Self-Direction Budget template for FSS Providers on the Direct Provider Purchased tab. Brokers can and should input all the provider names into this field. Individuals who self-direct and are applying for FSS reimbursement must include total FSS expenses in their Self-Direction budget. All FSS funded services (if received through multiple FSS providers) should be included in the budget even if they cannot be itemized. Any FSS reimbursement is counted towards their total Personal Resource Account (PRA). The Total Annual Cost for FSS on the Self-Direction budget needs to be the aggregate amount across all providers. The Life Plan, as a corresponding document which supports Self-Directed budgeted services, should list any/all FSS providers in the required Life Plan sections.
23.	Can families apply for multiple FSS reimbursements via multiple FSS providers in the same year?	Ideally, one provider per service should be used to avoid duplication and/or overpayments. For example, an individual should not be enrolled in multiple FSS Family Reimbursed Respite programs (situationally and only with pre-approval from the RFO). However, OPWDD recognizes that there may be occasions where an individual/family may benefit from receiving separate and distinct FSS services from multiple agencies (e.g.: sibling support group, FSS Family reimbursement for goods, FSS camp...). In these cases, accessing multiple providers-- as justifiable and approved-- may occur. It is the responsibility of the CM (as applicable) to alert FSS Providers to changes in individual's status, need, or eligibility. All needs and services should all be current and appropriately documented by CM in the Life Plan. It is the responsibility of FSS Providers, with oversight provided by their RFO, to collaborate and coordinate with partnering FSS providers who may also offer FSS Family Reimbursement services to avoid duplication as well as over-utilization of funds beyond the $3,000 allowable annual cap. Throughout the contract year, FSS Providers should routinely review their FSS program enrollments in CHOICES to ensure that rosters are current and accurately reflect enrollments/terminations and to monitor any service conflicts/overlaps which may disallow funding.

Frequently Asked Questions Regarding the OPWDD FSS Family Reimbursement ADM 2022-02R

Responses as of June 10, 2024

	Question	Response
24.	Can a non-family member who resides within the individual's home provide respite?	No. Respite providers, whether they are related to the individual or not, must reside outside of the individual's home.
25.	Can an individual access FSS during the redetermination process (during the period between Provisional and Full eligibility status)?	Eligibility for children who are first determined *provisionally* eligible for services must be reviewed again by the (RFO) prior to the child's eighth birthday. The eligibility department will notify the family, and if applicable, CCO, of the need for updated documentation for this review prior to the child's eighth birthday to ensure continuity of services and eligibility. To avoid any lapse in needed or beneficial supports throughout this period of eligibility reassessment, FSS services can continue until the time a final determination of eligibility is issued by the RFO (for example, this timeframe may extend beyond the person's 8th birthday until the final determination is issued). This allowance extends to both existing FSS programs and services the individual/families may receive/be enrolled in (such as family reimbursement). Newly requested FSS services cannot be supported for individuals eight years or older who have not had their provisional eligibility reassessed.

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

Non-Allowable Items, Continued:

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: