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## **FAMILY REIMBURSEMENT FOR BROOKLYN**

**July 1, 2019 thru June 30, 2020**

This program can reimburse families for money spent caring for their loved ones who have been diagnosed with Developmental Disabilities. Applications will be reviewed based on need by the agency and with final review by DDRO.

### **Program Requirements:**

- Individual **must** reside in the borough of Brooklyn.
- Individual must be diagnosed with Developmental Disabilities.
- The individual must be **OPWDD eligible**, with a **TABS** number. You can contact your Care Coordinator for your 6-digit TABS number.
- Please provide a **psychological evaluation** that clearly demonstrates eligibility.
- You must provide evidence of OPWDD eligibility by providing ONE of the documents below:
  - OPWDD eligibility determination letter
  - A current Level of Care Determination (LOC)
  - MSC or Care Coordination approval letter
  - HCBS Waiver Notice of Decision
- The application and respite verification forms must be completed in full, to include all necessary supporting documentation, with original signatures.
- You must submit all **original , paid in full** receipts(should the receipt not indicate an item description then the tags on the clothing must be included in the submission) and they must be numbered and listed on the **“Receipts Form for Reimbursement”** page of the Reimbursement package.
- Receipts must be dated between **7/1/19 – 6/30/20**.
- **If an application is not completed in full, it will not be processed. It will be returned with a letter of explanation.**

### **Limitations:**

Each diagnosed individual **MAY** be awarded up to \$500.00 once a year.

**APPLYING FOR REIMBURSEMENT DOES NOT GUARANTEE REIMBURSEMENT FUNDS!**

#### **NYFAC MAY cover:**

- Clothing (**does not include uniforms**)
- Recreation Programs
- Respite (**Babysitting**)
- Evaluations (Psychological and Psychosocial)
- Adaptive equipment that clearly shows developmental benefit to the individual
- **Camp with a paid in full receipt and evidence of attendance dates**

#### **NYFAC will NOT cover:**

- Computers/computer software
- Electronic devices
- Music players (iPods, headphones)
- Supplements/Vitamins/Diapers/
- Feminine care items
- Music, swimming or other Lessons/Therapy
- Furniture/bedding
- Taxes & Shipping Fees are not reimbursable
- Tuitions & Membership Fees
- Toys

# **BROOKLYN APPLICANTS ONLY!!!**

## **Family Support Reimbursement Application**

### **Applicant's Information**

Date: \_\_\_\_\_

Applicant's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Soc. Sec #: \_\_\_\_\_ Medicaid#: \_\_\_\_\_ TABS #: \_\_\_\_\_

Address: \_\_\_\_\_

Applicant's Developmental/Intellectual Disability : **Check all that apply**

Intellectual Disability  Autism  Cerebral Palsy  Down Syndrome  Neurological Impairment

Epilepsy  Traumatic Brain Injury  Other (specify) \_\_\_\_\_

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### ***FAMILY INFORMATION***

Applicant's Parent/Caregiver: \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cellular Phone: \_\_\_\_\_

Email address: \_\_\_\_\_

### ***OTHER INFORMATION***

**IS THE APPLICANT ENROLLED IN "SELF-DIRECTION?"**  Yes  No

Have you applied for goods and/or services from other family reimbursement providers ?  Yes

No

If yes please specify:

<b>Agency</b>	<b>Amount</b>	<b>Name of Goods/Services</b>
	\$	

Have you applied to any other family reimbursement provider to fund this request?  Yes  No

If yes please specify:

<b>Agency</b>	<b>Amount</b>	<b>Name of Goods/Services</b>
	\$	

**JUSTIFICATION**

1. Describe the items/services requested for reimbursement.

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2. Describe how the items/services requested will directly benefit the applicant.

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Amount of reimbursement being requested: \_\_\_\_\_

Person's name that the check should be made out to: **(Must be the Parent or Guardian)**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address (if different than applicant):

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I hereby certify that the information on this application is correct and I understand that any reimbursement I receive will go to the Booklyn Agencies Reimbursement Data System. I also understand that my total reimbursement will not exceed my total expense. I have attached my **original receipts/records and supporting documents** where necessary.

Parent/Guardian (Please print clearly)	Address:
Signature:	Date:

If you have any questions or need assistance in completing this application,  
please contact your Care Coordinator.

Upon Completion please forward to:  
New York Families for Autistic Children, Inc  
164-14 Cross Bay Boulevard, Howard Beach, NY 11414  
Attn: Family Support Coordinator

**New York Families for Autistic Children**  
**Family Support Services - Reimbursement**

Your name (Primary Caregiver)	Address	Borough/Zip Code
Telephone Number	Work Telephone Number	Cell Number

Complete the income scale below for the applicant's household:

Total Family Income (Including Benefits or Entitlements such as SSI, Public Assistance, etc.)

Income Amount:	\$1 to \$24,999	_____
	\$25,000 to \$49,000	_____
	\$50,000 to \$74,999	_____
	\$75,000 to \$99,000	_____
	\$100,000 and Over	_____

Number of adults in household: \_\_\_\_\_

Number of children in household: \_\_\_\_\_

Name of Care Coordinator: \_\_\_\_\_

CCO Agency Name: \_\_\_\_\_

Agency Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_



**FAMILY SUPPORT SERVICES  
MUST BE FILLED OUT, SIGNED BY RESPITE PROVIDER (Babysitter)  
& NOTARIZED IN ORDER TO RECEIVE REIMBURSEMENT**

**Receipt for Respite**

**Individual's Name:** \_\_\_\_\_

**Provider's Name:** \_\_\_\_\_

**Provider's Address:** \_\_\_\_\_

\_\_\_\_\_

**Provider's Phone#:** \_\_\_\_\_

**Where is the respite care (babysitting) provided?**

**Address:** \_\_\_\_\_

**Phone #:** \_\_\_\_\_

\_\_\_\_\_  
**Parent's Signature**

\_\_\_\_\_  
**Today's Date**

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\_\_\_\_\_  
**Provider's Signature**

\_\_\_\_\_  
**Today's Date**

Sworn to me this \_\_\_\_\_ day  
of \_\_\_\_\_, 20\_\_\_\_\_.



\_\_\_\_\_  
**Notary Signature**

**Notary Stamp**

