NYFAC
NEW YORK FAMILIES FOR AUTISTIC CHILDREN
164-14 Cross Bay Boulevard
Howard Beach, NY 11414
P. (347) 566-3122
F. (718) 641-1972

FAMILY REIMBURSEMENT FOR QUEENS
July 1, 2021 thru June 30, 2022

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 the DDRO.

Program Requirements:

- Individual **must** reside in the borough of Queens.
- 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 must be completed in full, to include all necessary supporting documentation, with original or electronic signature of parent/advocate.
- ***You must submit all original, paid in full receipts with proof of payment method and online purchases must include the shipping/packing/return label*** (should the receipt not indicate an item description then the tags on the clothing must be included in the submission), they must be numbered and listed on the **"*Receipts Form for Reimbursement*"** page of the Reimbursement package.
- Receipts must be dated between **7/1/2021 – 6/30/2022**.
- **If an application is not completed in full, it will not be processed.**

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
- Recreation Programs
- Music, Swimming or other Lessons
- Furniture/Bedding
- Adaptive equipment that clearly shows developmental benefit to the individual (with clinical justification and proof of Medicaid denial)
- **Camp with a paid in full receipt and/or current balance due, evidence of dates of attendance & NYC DOH Permit to Operate.**

NYFAC will *NOT* cover:

- Respite/Babysitting
- Camp outside of NYC
- Computers/Computer software
- Electronic devices
- Music players (iPods, headphones)
- Supplements/Vitamins/Diapers/ Feminine care items
- Evaluations
- Therapy
- Taxes & Shipping Fees are not reimbursable
- Tuitions & Membership Fees

QUEENS 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 ❑ Cererbal Palsy ❑ Down Syndrome ❑ Nuerological Impairment

☐ Epilepsy ☐ Traumatic Brain Injury ☐ Other (specify) _____

FAMILY INFORMATION

Applicant's Parent/Advocate: _____

Relationship to Applicant: _____

Home/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:

Agency	**Amount**	**Name of Goods/Services**
	$	

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

If yes please specify:

Agency	**Amount**	**Name of Goods/Services**
	$	

JUSTIFICATION

1. Describe the items/services requested for reimbursement.

_____
_____
_____
_____
_____

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

_____
_____
_____
_____
_____

Amount of reimbursement being requested: _____

Person/Advocate/Camp/Vendor name that the check should be made out to:

Person/Advocate First Name: _____ Last Name: _____

Camp/Vendor: _____

Address (if different than applicant):

_____

I hereby certify that the information on this application is correct and I understand that any reimbursement I receive will go to the Queens Agencies Reimbursement Data System. I also understand that my total reimbursement will not exceed my total expense. I have attached my **original receipts/proof of payment method/shipping/packing/return lables 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 Assitance, 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: _____

Receipts Form for Reimbursement

Please list and summarize <u>each</u> original receipt below. The receipt # listed on this page should correspond with the number written on each submitted receipt.

RECEIPT #	DATE OF PURCHASE	GOODS OR SERVICES SUMMARY	TOTAL REIMBURSEMENT REQUESTED
EXAMPLE: **#1.**	**10/01/2021**	**Winter Coat**	**$85.00**
#1.			

Total Amount: _____