Dear Sir or Madam:

Thank you for your inquiry about the Family Service Support Reimbursement Program. I have enclosed an application for you to complete and return as soon as possible. In order for your application to be considered by the Parent Advisory council you must also submit:

- **Original Receipts** for the item(s) you have purchased. If it’s an invoice for an activity, the invoice **MUST** specify the fee per hour and dates the individual attended. Receipts must be within the fiscal year that starts on July 1, 2019 and end on June 30, 2020.

- **Support Letter:** You **MUST** submit a support letter explaining why the item is needed. The letter should be from your Medicaid Service Coordinator or a Doctor/Clinician if it is regarding a clinical need.

The Parent Advisory Council will NOT consider applications that are submitted without the above proof of disability. Also, in most cases $500.00 is the maximum amount allowed on reimbursement request however decisions are made based on the clinical and family needs.

*Please direct all questions and concerns regarding Manhattan, Brooklyn, Queens and Staten Island to Ashley Farrice at (718) 667-4263 ext 112 or by email at afarrice@cfsny.org*

Sincerely,

The Family Support Services Department

Enclosure
THE CENTER FOR FAMILY SUPPORT, INC.

FAMILY SUPPORT SERVICES REIMBURSEMENT APPLICATION

88 NEW DORP PLAZA- SUITE 101- STATEN ISLAND, NY 10306

Date: __________________________

Applicant’s Name: __________________________ D.O.B: __________________________

Medicaid #: __________________________ TABS ID: __________________________

Developmental Disability: __________________________

Address: __________________________

Phone #: (Home) __________________________ (Cell or Work) #: __________________________

Parent/ Caregiver Name: __________________________

Number of People in the Household: __________________________

Please list the Names and Ages of other children in the household: (Indicate if any have disabilities):

__________________________

Do you have extraordinary expenses? Ex: Do you take care of other family members such as a grandparent, aunt, uncle, etc. Explain:

__________________________

Please indicate TOTAL Family income: __________________________

What goods and/or Service do you wish to purchase? Goods: _______ Amount: $ _______

What specific item: __________________________

Why are those goods/services necessary?: __________________________

If applying for the following items, please indicate the following sizes? Shoes _______ Shirts _______ Pants _______

Is the individual enrolled in a self-direction program? _______ Yes _______ No

(Original Receipts must be attached in order for your application to be reviewed)

Have you applied elsewhere? _______ Yes _______ No

Were you approved? _______ Yes _______ No

How much were you approved for? $ _______

__________________________

DO NOT WRITE BELOW THIS LINE- FOR OFFICE USE ONLY

Date of Review: ____________ Amount Approved for: ____________ Date of Admittance: ____________

Approved: __________________________ Not Approved: __________________________

Reason for Disapproval: __________________________