SI Family Reimbursement REV. 7/19

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***FOR STATEN ISLAND INDIVIDUALS ONLY***

OPWDD DDRO - Region 4, Staten Island
**Family Reimbursement c/o Mr. John Wynne**
**930 Willowbrook Rd. Bldg. 12G; Staten Island, New York 10314**
**PLEASE PRINT CLEARLY**

| For office use only | | |
|---|---|---|
| Application Reg. # | OPWDD Elig / Care Manager: | Date: |

***Applicant Name:** _____ ***TABS ID** _____
(Individual Who Has a Developmental Disability)

*Date of Birth: ____/____/____ is the applicant living with parent? Yes ☐ No☐

Primary Diagnosis: _____

**Parent Name:** _____

**Parent Address:** _____ **APT:** _____ **STATEN ISLAND, NY**

**Zip Code:** 103_____ **Phone No.:** _____ **Email:** _____

**Name of person completing application, if other than parent:** _____

**Agency (if any):** _____ Address: _____

Telephone No.: _____ ***EXT:** _____ **Relationship to Applicant:** _____

**Email:** _____

Please check if the applicant receives any of the following:

Medicaid ☐ Medicaid Waiver ☐ S.S.I ☐ Insurance☐ Medicare ☐ **Self Direction ☐

**If applicant has Self Direction, funding for this service must be included in the budget.

**Goods or Services Requested:** _____

_____

**Reason for Reimbursement:** _____

_____

***Cost For Above Request:** _____

***Are you receiving any other sources of funding for this request:** Yes ☐ No ☐

**If Yes – Please explain:** _____

***To Whom Should The Check Be Issued?** _____

***Where should it be sent?** _____

Have You Ever Received Family Reimbursement? Yes ☐ No ☐

Most Recent Date of Your Last Award: ____/____/____ Agency (if known): _____

***- required fields**

**PLEASE BE AWARE – THE FISCAL YEAR RUNS FROM JULY 1, 20XX TO JUNE 30, 20XX.**

**WE CANNOT REIMBURSE FROM ANOTHER FISCAL YEAR'S BUDGET**

**ATTACH ORIGINAL RECEIPTS TO THIS FORM FOR CONSIDERATION.**

**Only this standardized application will be accepted and considered for any Staten Island Reimbursement award.**

**Please turn application over in order to sign and complete →**

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**A Family Reimbursement Application may be submitted once per fiscal year. Priority will be given to those persons applying for the first time. For all other applicants, a review of previous reimbursement history will be taken into consideration. If a family is in financial crisis and needs immediate assistance, they should contact Mr. John Wynne at: 718-982-1943 for guidance.**

All applicants must have established OPWDD eligibility.

**Sign the appropriate statement**

I have submitted **THE ORIGINAL** bill for the requested goods or service.

Signature: _____ Date ____/____/____
Parent and/or Care Manager

**OR**

**For families unable to make an initial outlay, please call John Wynne at (718) 982-1943.**

I have attached an estimate for the requested goods or service. **Once the purchase is completed, I agree to submit a receipt and return any unused funds within thirty days of purchase.**

Signature: _____ Date ____/____/____
Parent

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