

**OPWDD REGION 1 Universal Application for FAMILY REIMBURSEMENT SERVICES  
A funding source of LAST RESORT**

**1. PERSONAL DATA: (please print)**

Name of Person with Disability: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Name of Parent/Relative: \_\_\_\_\_ Number of People in the home: \_\_\_\_\_

TABS #: \_\_\_\_\_ Medicaid #: \_\_\_\_\_ Check if the individual Receives: \_\_\_ Self Direction \_\_\_ HCBS Waiver

Developmental Disability:

\_\_\_ Intellectual Disability \_\_\_ Epilepsy (seizures) \_\_\_ Cerebral Palsy \_\_\_ Neurological Impairment  
\_\_\_ Autism \_\_\_ Traumatic Brain Injury Other: \_\_\_\_\_

**2. HAVE YOU TRIED FOR FUNDING FROM PRIMARY MEDICAL INSURANCE, INCLUDING FLEXIBLE SPENDING ACCOUNT, OR OTHER RESOURCES? (i.e. Medicaid, Medicare, etc.)**

\_\_\_ Yes \_\_\_ No Result: \_\_\_\_\_

**3. LIST ALL REIMBURSEMENT AMOUNTS RECEIVED THIS CALENDAR YEAR: (add a page if needed) N/A: \_\_\_\_\_**

Agency: \_\_\_\_\_ Date: \_\_\_\_\_ Amount: \_\_\_\_\_ Agency: \_\_\_\_\_ Date: \_\_\_\_\_ Amount: \_\_\_\_\_

Agency: \_\_\_\_\_ Date: \_\_\_\_\_ Amount: \_\_\_\_\_ Agency: \_\_\_\_\_ Date: \_\_\_\_\_ Amount: \_\_\_\_\_

**4. WHAT IS THE ITEM(S) OR SERVICE REQUESTED FOR REIMBURSEMENT? Describe item(s): \_\_\_\_\_**

Total Amount Requested: \$ \_\_\_\_\_ Date of service requesting for: \_\_\_\_\_

*\*Is this item/service to meet an immediate crisis situation as identified in the guidelines? \_\_\_ Yes \_\_\_ No*

**5. LIST OTHER REIMBURSEMENT AGENCIES APPLIED TO FOR THIS PARTICULAR REQUEST: N/A: \_\_\_\_\_**

Agency: \_\_\_\_\_ Date: \_\_\_\_\_ Result: \_\_\_\_\_

Agency: \_\_\_\_\_ Date: \_\_\_\_\_ Result: \_\_\_\_\_

**6. SERVICE COORDINATOR OR SOCIAL WORKER: Name \_\_\_\_\_**

**Agency**

**Email**

**Phone #**

**Fax #**

**7. CHECKLIST OF REQUIRED DOCUMENTS: (Please attach to this application)**

- \_\_\_ Original Receipts or Invoice (list which agency has the originals if copies are submitted)
- \_\_\_ Letter from Physician or Professional to Support Reimbursement Request (if applicable)
- \_\_\_ Notice of Decision or other OPWDD Eligibility Document Approved by the Access Team **(If current documentation is not on file with provider agency)**
- \_\_\_ Copy of current budget if enrolled in Self Direction

**\*\*\*Final determination of eligibility for Reimbursement Services will be determined by OPWDD\*\*\***

**8. HOW DOES THIS REQUEST DIRECTLY RELATE TO THE INDIVIDUAL'S DISABILITY? (Please add a page or reply in 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.*

**\*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 1 DISTRICT:**

\_\_\_\_\_  
**Original Family Signature** (No photo copies accepted)

\_\_\_\_\_  
**Date**

**Please return application to:** *(Your agency info here)*