Fiscal Year: **2017** Date of Request: _____

UNIVERSALREIMBURSEMENT REQUEST

ACDs, Angela's House, Nassau AHRC, Citizens, Suffolk AHRC, East End Disability Associates, Inc., FREE, Head Injury Association, Greater 5 Towns JCC, LIFE, LIDDRO, SCO Family of Services, UCP Nassau & UCP Suffolk

(In order to be processed please answer every question)

Applicant: _____ Date of Birth:_____Age:_____

Applicant's sex: (Circle One) Male or Female Medicaid Number: _____ Tabs#:_____

Address: _____City:_____Zip Code: _____

Applicants Social Security #: _____ School/Day Program: _____

Parent/Guardian: _____ Phone #: _____

Parent/Guardian e-mail address: _____

Ethnicity: (For Demographic purposes only) ___African-American ___Asian/Pacific Islander ____Hispanic ___Native-American ___White ___Other

Have you applied to/been approved for reimbursement from any of the above agencies?

Yes __ No __ If yes, what agency: _____ When:_____

Does applicant have private medical insurance? No___ Yes___

Check if the applicant is enrolled in and receiving funding/services from either of these programs:

HCBS Waiver _____ Care at Home _____ Self Direction_____

List all members of household:

Name	Age	Occupation	Health Status
_____	___	_____	_____
_____	___	_____	_____
_____	___	_____	_____
_____	___	_____	_____
_____	___	_____	_____

Check your current household income:

Under $50,000 _____ $80,000-95,000 ____ $110,000-150,000 _____
$50,000-65,000 _____ $95,000-110,000 ____ Over $150,000 _____
$65,000-80,000 _____

Disabilities: Indicate "1" for primary (mark only one) and "2" for all other(s) that apply:

__ 1. Intellectual Disability
__ 2. Autism
__ 3. Cerebral Palsy
__ 4. Epilepsy/Seizure Disorder
__ 5. Other Neurological Impairment
__ 6. Psychiatric/Emotional Disability
__ 7. Chronic Physical/Med. Condition
__ 8. Sensory Impairment
__ 9. Traumatic Brain Injury
__10. Other_____

Reimbursement:

1. What specific service(s) or goods are you requesting funds for?
   (If requesting reimbursement for a service in which the school already provides, please send in a copy of the most recent IEP)

Service (respite,camp,etc.)	**Anticipated Cost**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Items (diapers, wipes, etc.)	**Anticipated Cost**
_____	_____
_____	_____
_____	_____
_____	_____

2. Name of payee to be reimbursed: _____

3. What is the payee's Social Security Number: _____
   (**We cannot process without this number**)

By signing below, I am attesting that I have not or will not accept reimbursement from any other agency this fiscal year. I understand that doing so will jeopardize consideration for future funding.

"I have read and agree to adhere to the reimbursement guidelines."

_____ _____

Parent/Guardian Signature **Date**

Please note: A new application must be completed for each fiscal year.

For Office Use Only:

New or Renewal: _____ *Committee Meeting Date:* _____

	Date	Amount	
Approved:	_____	_____	FSS # _____
Denied	_____	_____	Pending: _____

FSS Staff Responsible _____

Revised 12/3/15