Fiscal Year: **2022** Date of Request: _____

UNIVERSAL REIMBURSEMENT REQUEST

(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: _____

Applicant's Social Security #: _____ School/Day Program: _____

Parent/Guardian: _____ Phone #: _____

Parent/Guardian e-mail address: _____

Care Manager name/phone/email 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 following agencies?
ACLD, Angela's House, Nassau AHRC, Citizens, Suffolk AHRC, DDI, FREE, Head Injury Association,
The Marion and Aaron Gural JCC, LIDDRO, SCO Family of Services, UCP Nassau or UCP Suffolk

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_____

Justification of Need (how services/items needed are related to the individual's developmental disability)**:**
_____
_____
_____
_____
_____

List ALL members of household including applicant:

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

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 12/28/21