Request for Family Respite Reimbursement

Amount Requested: $

Name of Applicant:

Address:	Phone:
City/State	Cell Phone:

DOB:	**Medicaid #:**	**Tabs #**:

Type of Disability:
Current Medicaid Service Coordinator/Agency (if applicable):

Name of Legal Guardian (if applicable):

Please check the appropriate box below

Request for Existing Person	Request for New Person	One Time Only Request

The following people will be providing services: (please use the back of form if more space is needed)

Legal Name:	Legal Name:
Address:	Address:
Phone:	Phone
SS#	SS#

Total Monthly Income: __________________ Check will be made payable to (**check one**) _______Family _______Vendor

How does the requested fund benefit the individual with the development disabilities or support the family?

What other funding sources have been explored? ____

I have reviewed the Family Reimbursement guidelines and certify all the above information has been reviewed (by family if applicable) is correct and no other funding sources are available to fund this support. *** ***Please note: Arc of Onondaga pays a maximum amount of $9.00 per hour for services. Any amount accrued above $9.00/hour will be the responsibility of the family to reimburse the vendor. The family is responsible for informing vendor of the maximum payment rate.***

Print Name of Person: ____

Signature: ____ Date:________________

Arc of Onondaga's Use Only

Approved annual amount: $	Date Approved:
MSC Manager's Signature:	Approval Thru Date:
Increase over previous year?	How Much?