QCP
QUEENS CENTERS FOR PROGRESS
Services for People with Developmental Disabilities

"FAMILIES FIRST"
A Family Reimbursement Program

Date_____ **TABS ID #**_____

Name of Individual_____ DOB_____
Address_____ Telephone#_____
Social Security#_____/_____/_____
Parent/Guardian_____ Telephone#_____
Email_____

Individual's Primary Diagnosis_____

Care Manager_____ Telephone#_____
CCO_____ Email_____

Referring Person/Agency_____Telephone#_____
Address_____Relationship_____

Individual's School/ Adult Program_____
Address/ Telephone #_____

Please answer the following questions:
1. What is the individual's primary diagnosis?_____

2. Explain why the individual's urgent need should be funded by Family Reimbursement:
_____
_____
_____

3. Is this request an emergency? ☐ Yes ☐ No

4. How much money is needed?_____

5. What services or items will the money be used for?_____
_____
_____
_____

6. Have you received any Family Reimbursement grant within the past 12 months? (Y / N)
If you mark YES, indicate agency or program that provided the grant. How much was received and what it was used for?_____
_____
_____

7. LIST ALL REIMBURSEMENT APPLIED FOR AND/OR RECEIVED THIS CONTRACT YEAR: (add a page if needed). This information **MUST** be reported. Please be advised that $3,000 is the maximum total amount that may be reimbursed. If you have a large reimbursement request that exceeds an agency internal cap and you are submitting to multiple agencies for partial reimbursement, you must indicate this in the spaces below.

AGENCY	DATE	AMOUNT	APPROVED	DENIED	PENDING

8. Have you tried other ways to fund this request? □Yes □N What were the results of your efforts?

_____

_____

_____

9. Do you receive any of these benefits? If you do, please state your ID number:

Medicaid_____ Medicare_____

TANF (Temporary Assistance to Needy Families) $_____

WIC (Women/Infant/Child Program) _____ Public Assistance $_____

SSI $_____SSA $_____Food Stamps $_____

Unemployment Income $_____ Employment Income $_____

10. Is there anything else we should know about the individual and his/her circumstances?

_____

_____

_____

11. HOW DOES THIS REQUEST DIRECTLY RELATE TO THE INDIVIDUAL'S DISABILITY? Please add a page or reply in the area below. Be specific and provide justification as appropriate

_____

_____

_____

_____

_____

Completed by:_____ Date_____

Relationship to Individual_____ Telephone #_____

Individual's signature_____ Date_____

*Advocate's signature_____ Date_____

PLEASE ATTACH ALL RECEIPTS RELATED TO THIS REQUEST. THIS FORM MUST BE SUBMITTED WITH THE INDIVIDUAL'S CURRENT LIFE PLAN.

***PARENT or ADVOCATE SIGNATURE IS REQUIRED**

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT:

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or Marisa Fojas 718) 380-3000 Ext 251 mfojas@queenscp.org