NEW YORK STATE OF OPPORTUNITY. Office for People With Developmental Disabilities

Family Reimbursements Tracker Instructions

Column	Instructions
A	Enter DDRO, Choose from Dropdown Menu
B	Enter District, Choose from Dropdown Menu
C	Enter Reimbursement Type, Choose from Dropdown Menu
D	Enter County of Residence of the individual receiving services
E	Enter FSS Provider Agency
F	Enter Individual's Last Name
G	Enter Individual's First Name
H	Enter Individual's TABS ID #
I	Enter Yes or No if the Individual is enrolled in Medicaid Choose from Dropdown Menu (Yes or No)
J	Enter Yes or No if the Individual is enrolled in the Waiver which includes the HCBS children's waiver Choose from Dropdown Menu (Yes or No)
K	Enter if Individual receiving services is enrolled in Self-Direction, Choose from Dropdown Menu (Yes, Start-up or No)
L	Enter if the individual has a DDP-1 listing FSS services being received, Choose from Dropdown Menu (Yes or No)
M	Enter the name of the person receiving the reimbursement
N	Enter Yes or No if the Request was Reviewed by the Provider's FSS Committee Prior to Submission to the DDRO Choose from Dropdown Menu (Yes or No)
O	Enter date the reimbursement was requested (date application was submitted)
P	Enter date the reimbursement was approved (date the provider approved application unless being sent to Central Office for further review)
Q	Enter Item (Good or Service) that is being requested
R	Enter Description of Item
S	Enter Cost of Item i.e. the total amount being requested for reimbursement
T	Enter if the reimbursement is one-time only or ongoing; if ongoing provide the frequency i.e. 4 times per session at $xx per session for 6 months Choose from Dropdown Menu (One Time or Ongoing)

U	Enter the frequency of the request if it's an ongoing request
V	Enter Yes or No if the individual resides at home with family and/or caregiver Choose from Dropdown Menu (Yes or No)
W	Enter the clinical justification supporting the need for the requested item along with the connection to the individual's disability and life plan, if applicable/enrolled in a CCO. The clinical justification must be clinically indicated and substantiate the need for the item or service that is being requested. The clinical justification must be supported by a clinician and demonstrate a clear connection to the individual's developmental and/or intellectual disability. Clinical justification from clinician(s) working within their scope of practice including but not limited to physical therapist, occupational therapist, speech therapist, physician, behavior specialist, registered nurse, is acceptable. The clinician must provide a signed letter dated within a year of request (on formal letterhead) that demonstrates the need based on the criteria listed above in this paragraph.
X	Enter how this item supports keeping the individual at home with their family/caregiver and reduces the potential for a more restrictive placement or intervention.
Y	Enter what the most cost-effective items were explored and explain why more cost-effective alternatives were not chosen if they were available
Z	Enter website link to the item
AA	Enter what alternative funding sources were explored i.e. Waiver services or self-direction, if already accessing, other community resources and what the outcome was
AB	Enter if the individual is enrolled in a care coordination organization (CCO) Choose from Dropdown Menu (Yes or No)
AC	Confirm that any services or items that help support, enhance a skill, behavior or need that is associated with the disability is listed in the life plan and why the item is needed (only applicable if individual is enrolled in a CCO)
AD	Enter any additional notes as needed