FAMILY SUPPORT CATEGORY FUNDING INVOICE

Boundless

1021 Checkrein Avenue   Columbus, Ohio 43229-1106   614/844-5847   Fax 614/844-5916

***ALL FAMILY& VENDOR SIGNATURES, ADDRESS UPDATES AND INFORMATION REQUIRED**

PP/CTE Quarterly ☐1st, ☐2nd, ☐3rd, ☐4th OR	A/E,S/D,H/M,OT Quarterly ☐1st, ☐2nd, ☐3rd, ☐4th	*Total Hours	*Total Cost	☐Reimbursement ☐Purchase Order

***Family's Name & Address**

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____

* ☐Check if new address

*** Vendor's Name & Address**

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* ☐Check if new address

Signatures indicate funding is only for prior provided respite service- advance respite payment is not authorized

***Family Signature**____________________________ *** Vendor Signature**____________________________

Private Provider & CTE Quarterly Funding (check one)	***Quarterly Funding for "Items" Category (check one)***
*☐ ***Private Provider 7615***	*☐**Adaptive Equipment 7678** *☐**Special Diets 7606**
*☐**Counseling, Training & Education (CTE) 7679**	*☐***Home Modifications 7608*** *☐***Other 7607***
***Insurance co-payment_________%**	***Insurance co-payment_________%**

************** *An Important Note to All Families* **************

To assure payment and/or reimbursement of prior requested and approved Private Provider and CTE or Adaptive Equipment, Special Diets, Home Mods and Other categories invoices must be received by the last day of the quarter, (For example, July, August and September invoices (3rd quarter) must be received by September 30th. Otherwise, Family Support will assume that funds were not used and will be closed out and made available for other families for use in the future. All invoice forms missing family signatures and/or vendor signatures or other necessary information will be returned to the enrolled family only. A vendor receipt must be attached in order for family(s) to be reimbursed. Family Support is not responsible for the U.S Mail and/or invoices forms arriving late for payment. Please call the Family Support department at (614) 844-5847 with any questions. * Faxes cannot be accepted unless previously authorized by the FRS department

***Use only one vendor per invoice**

*** Use only one invoice per each type of service (advance payment for family chosen respite is not authorized-receipts appreciated)**

FOR OFFICE USE ONLY: Date Received______________________ Income Level____________________

Total Service Hours________________

Amount of Request

Code ___________________________

Family Co-Payment --

____

Family Resources Administrator

Amount Denied --

____

Ed Harper, Director

Amount Paid/Reimbursed by Family Resources

Date Paid__________________ Check Number_________________ Issued By___________

Complete back of page for category funding requests for Adaptive Equipment, Special Diets, Home Mod and Other Only

RECEIPTS MUST BE ATTACHED FOR DIRECT FAMILY REIMBURSEMENT TO FAMILIES.

ALL INFORMATION MUST BE ABLE TO BE CLEARLY READ

Reverse side must be completed also

Description of Item (required) :

Vendor Name and Address (required):

Total Cost of Item(s) required-(this may include a quote from the company):

Professional Statement of Need (required-may be attached):

Signature (required): ___________________________

Family Statement of Need (required-may be attached):

Individuals name ______________ Date of Birth___________

Family Signature (required): ___________________________

Steps you have taken towards seeking funding-filed applications

Mobile___ BCMH____ Medicaid____ Group insurance or private insurance____ Labor Union membership___ Individual Options___
Other (specify)____________________
Have you exhausted all other resources you are aware of? Yes___ No ___
If the foregoing does not provide funding, perhaps you may investigate non-public programs, i.e. local offices of large corporations, local business with fund for community programs, private foundations, volunteer agencies that may be applicable to your request.

Request approved __________ Request Denied ____________(see attached)

1. **If you are requesting reimbursement from the Family Support program for items in the Adaptive Equipment, Home Modifications, Special Diets of Other categories a receipt for the items must be attached. Full reimbursement is not guaranteed due to limited allocation levels of the Family Support Program. Families must have requested a funding allocation in these categories previous to submission of the request. All information must be complete and request must meet criteria of the mission of the Family Support Program.**

All New Family chosen Vendors must be accompanied by a completed W-9 form or the Funding Invoice will be returned to the family.

2. **If you are requesting that Family Support program pay the vendor directly for the items identified on this form through a "Purchase Order" in the Adaptive Equipment, Home Modifications, Special Diets of Other categories all requested information must be complete. Full reimbursement is not guaranteed due to limited allocation levels of the Family Support Program. Families must have requested a funding allocation in these categories previous to submission of the request. All information must be complete and request must meet criteria of the mission of the Family Support Program.**