Developmental Disabilities Supports Division (DDSD)
Family Supports and Reimbursement Program Application
Fiscal Year 2020

Date of Request: _____

General Information

Family Member/Person submitting the application: _____

Relationship to Individual: _____

Address of the Person submitting the application: _____

City: _____ State: _____ Zip Code: _____

County: _____ Region: ❑ Metro ❑ NWRO ❑ NERO ❑ SERO ❑ SWRO

Phone: _____ Email address (if any): _____

Is it OK to leave a phone message? ❑ Yes ❑ No

Are you the Primary Contact? ❑ Yes ❑ No

If No – Please list the Primary Contact's name and contact information (phone and address):
_____

Applicant Information

First Name: _____ Last Name: _____

Date of Birth: _____ Gender: ___ Male ___ Female

Social Security #: _____

Address of the Applicant: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email address (if any): _____

Qualification Criteria

New Mexico Resident: ❑ Yes ❑ No

Has the applicant applied for Medicaid State Plan benefits? ❑ Yes ❑ No

Is the applicant Medicaid eligible? ❑ Yes ❑ No (If the answer is no, need to show proof of Medicaid denial)

Does the applicant have a Managed Care Organization? ❑ Yes ❑ No

Is the applicant on the Waiting List for the Developmental Disabilities Waiver? ❑ Yes ❑ No

Does the applicant meet the NM state definition for developmental disability? ❑ Yes ❑ No

Is the applicant receiving any other State General Funded Services? ❑ Yes ❑ No

Type of Service/Supports Requested:

Note: If you need assistance in completing this form please contact DDSD

Services/Supports Requested	**Name of Vendor/Provider**	**Requested date to begin services**	**Expiration End date for services Program Ends June 30th, 2020**	**Amount requested (total amount cannot exceed $1,470)**
				$
				$
				$
				$
				$
Total Amount Requested for the FSP Application				$

- Applications cannot be accepted for reimbursement for services rendered in a previous FSP application approval.
- Services will not be paid for if not authorized within the FSP application.
- The maximum amount you can request per applicant for the FSP application up to $1,470.00.

Agreement

Please read the following and provide the signature of the applicant or the applicant's legal guardian:

As the applicant/legal guardian for _____ , I have reviewed this application and confirm that, to the best of my knowledge, the information provided is accurate. I understand that, if there are any changes including the applicant becoming eligible for Medicaid or any Medicaid Waiver or State General Fund services, it is my responsibility to notify DDSD so their records can be updated accordingly. Upon approval of Medicaid or allocation to any Medicaid Waiver service, or approval to receive any State General Fund service, the applicant will no longer be eligible for the Family Supports and Reimbursement Program. I understand that if the applicant receives funding through this program, the Fiscal Management Agency who pays the providers will have access to relevant information in this application to accurately reimburse the providers/ vendors.

_____ _____

Signature of Applicant / Legal Guardian Date

_____

Printed Name

Please mail completed applications to:

New Mexico Department of Health, Developmental Disabilities Support Division
Attention: Juanita Salas, State General Fund Program Manager
5301 Central NE 11th Floor
Albuquerque, New Mexico 87108

Or email

Juanita.Salas@state.nm.us

For DDSD Official Use Only:

Services/Supports Approved	**Name of Vendor/Provider**	**Effective date Services can begin**	**Expiration End date for services Program Ends June 30th, 2020**	**Amount Approved (total amount cannot exceed $1,470)**
				$
				$
				$
				$
				$
Total Amount Approved for the FSP Application				$

Date Received: _____

Date Reviewed: _____

Approved: ❑ Effective Dates of Approval: _____

Denied: ❑ Reason for Denial: _____

_____

DDSD Staff Name and Title: _____

DDSD Authorized Staff Signature: _____