FLOWER CITY
DOWN SYNDROME NETWORK

Serving the Greater Rochester Area Since 1991

Service and Relevant Items Reimbursement Application

Before applying, please refer to the "FCDSN Reimbursement Program Policies"

Member Name: ______________________________ Date: ______________

Address: ____

City: ________________ State: ________ Zip Code: ___________ Phone:______________

Reimbursement is requested for the following:

Name of Individual with Down syndrome: ______________________________

Service: ______________________________Cost per hour: $________OR session: $__________

Service: ______________________________Cost per hour: $________OR session: $__________

Service: ______________________________Cost per hour: $________OR session: $__________

Item Description: ______________________________________Cost: $__________

Item Description: ______________________________________Cost: $__________

Item Description: ______________________________________Cost: $__________

Total reimbursement requested: $ [ ]

How will this item or service benefit the individual in a social, recreational manner? (criterion established by FCDSN Board for program) ____

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Signature of person completing form:______________________________ Date:______________

Original receipts are required prior to disbursement of funds. Keep a copy of your receipts and this submission for your own records. Submit complete (signed) application, with <u>original</u> receipts, to:

<u>FCDSN Reimbursement Programs, 2117 Buffalo Road #132, Rochester, NY, 14624</u>

Do Not Write In Box Below

Member in good standing? ☐ Yes ☐ No Verified by: ______________________________

Application: ☐ Approved ☐ Denied/Reason: ______________________________

Reply Mailed On: ________________ Check # __________ Amount: $______________

Entered: ☐ Date: ________________