FEE REDUCTION / WAIVER FOR PREEXISTING SERVICES REQUEST FOR APPROVAL

This form must be completed by a service provider and submitted, along with all requested documentation, to the appropriate OPWDD Financial Benefits & Entitlements Assistance & Management (FBEAM) Field Office (see the OPWDD website at www.opwdd.ny.gov for a list). Incomplete forms or forms lacking required documentation will not be processed and will be returned to the provider.

Name of Person Receiving Services: _____ Date of Birth: _____
TABS ID #: _____ Service Provider: _____
TABS Agency Code: _____ Service Provider Tax ID Number: _____
Service Provider Contact: _____ Phone #: _____
Service Provider Address: _____
Type of Service(s): _____
OPWDD TABS Program Code(s): _____
Type of Authorization Being Requested: Fee Reduction ☐ Fee Waiver ☐
Reason For Requesting a Fee Reduction or Waiver: _____

_____

_____

Provider's Calculation of the Maximum Amount to be Charged to the Individual Each Month (see Addendum 1 of process document *Liability for OPWDD Medicaid and Home and Community Based Waiver Services* for information about how to calculate): $ _____

MEDICAID STATUS

Is this person eligible for Medicaid? Yes ☐ No ☐ Pending ☐ Date application filed: _____
If ineligible, state reason for ineligibility: _____

_____

_____

_____

If the Medicaid application has been denied, attach photocopies of the following (check the box for each item attached):

- ☐ Medicaid Denial/Termination Notice
- ☐ Medicaid Fair Hearing Determination

AND

- ☐ Completed Benefit Eligibility Questionnaire (OPWDD Form 263-C)

OR

- ☐ Statement of total annual taxable income (pay stubs, direct deposit statement)
- ☐ Statement of assets (bank account statements, trust documentation, etc.)

If Medicaid has been denied on the basis of immigration status, also attach:

- ☐ Paperwork from United States Citizenship and Immigration Service (USCIS) documenting legal residence in the U.S.

If the individual is under 21 and living with his/her parents, what is the parents' yearly taxable income? $ _____

If a Medicaid application has not been filed, provide a detailed explanation (documentation of income and assets must be attached (see above) as well as any relevant documentation from USCIS or, if not available, provide a complete description of immigration status): _____

_____

_____

_____

_____

HCBS WAIVER STATUS

Not Enrolled: ☐ Ineligible ☐ Terminated ☐ Pending ☐ Date application filed: _____

Reason for Ineligibility/Termination, if Applicable (Attach Copy of Denial/Termination Notice): _____

_____

_____

ATTESTATION

I, the undersigned, on behalf of _____ attest that the information provided is true and
Service Provider
complete to the best of my knowledge and our agency is meeting its obligations under 14 NYCRR Subpart 635-12 *Liability for Services*. I understand that any omission or misrepresentation of information may result in financial liability to our agency.

Service Provider Signature _____ Date _____

Print Name: _____ Title _____

FBEAM FIELD OFFICE USE ONLY

☐ OPWDD approves reduction of fee for: _____
Service(s)
provided by _____
Service Provider
Amount to be Paid by the Individual or Liable Party for Services Each Month: $ _____
(Payments to this provider by OPWDD for the specified service(s) will be offset by this amount)

☐ OPWDD approves waiver of the fee for: _____
Service(s)
provided by _____
Service Provider

Approval period: _____ until _____ Apply by: _____
Date Date Date
to request approval of a waiver or reduction of fees for this individual after the expiration date.

☐ OPWDD **does not** approve the waiver or reduction of fee:
Reason: _____

_____

_____

_____

FBEAM Office Manager Signature: _____ Date: _____

***REQUIRED DISTRIBUTION*:**

Service Provider
DDSOO/SDIS
Field Operations
OPWDD Payment Processing Unit (approved forms only)