NEW YORK STATE INSTITUTE ON DISABILITY, INC. (NYSID)
930 Willowbrook Road, Bldg. 41-A
Staten Island, NY 10314
Office Phone 718 494-6457 / Cell Phone 929 202-1115
Fax 718 494-6461 EMERGENCIES ONLY
Email: info@nysidinc.org

Name of Applicant _____ Date of Birth _____/_____/_____

Home Address _____Apt #_____ Borough_____ Zip _____

Social Security # _____ Medicaid # _____ TABS ID_____

Diagnosis _____ OPWDD Eligibility Yes or No

Parent's Full Name_____ Email_____

Home Phone #/Cell Phone #_____ Family income _____

Care Coordinator/Manager _____ Email_____

Agency /CCO name _____

Address_____

Office Phone #_____Cell Phone #_____

WHAT SERVICE ARE YOU REQUESTING (ONE PER APPLICATION):

YOU MUST ATTACH A CURRENT LEVEL OF CARE ELIGIBILITY DETERMINATION (WITHIN ONE YEAR) OR FULL PSYCHOLOGICAL REPORT (WITHIN THREE YEARS)

1. **SPORTS & ENTERTAINMENT TICKETS** (4 tickets per family)
   _____
   Attach your prioritized list: please choose up to four venues

2. **CAR SERVICE REQUEST**_____
   Attach the car service request form. Family member must accompany the applicant – a limit of four (4) rides per family per fiscal year.

3. **FREE IN- HOME EVALUATIONS** (For non-Medicaid eligible persons only)
   Please submit an IEP, OPWDD request or letter from a doctor requesting evaluation
   Psychological _____ Psychosocial _____ Language spoken _____

4. Reimbursement Request for Individuals in Housing Subsidy Program_____
   Amount Requested: _____
   Check to be written to: _____

Answer all three of the following questions. Failure to do so will delay the processing of your application. It may also result in your application being RETURNED or DENIED.

Do You Receive Self-Direction Services? Yes or No

If yes, your application will not be accepted, as we do not provide sports and recreation tickets or transportation services for individuals with self-direction services.

Who is completing the application? Please circle below:

Parent Self Advocate Care Manager Family Member/ Representative/Other _____
(Specify)

Signature of Person Completing Application:

_____ **Date**_____

DIRECTIONS FOR COMPLETING THE NYSID APPLICATION

1. **THIS APPLICATION IS NOT TO BE USED FOR REIMBURSEMENT FOR GOODS & SERVICES. THAT APPLICATION IS AVAILABLE ON THE OPWDD WEBSITE. https://opwdd.ny.gov/system/files/documents/2023/05/attachment-a-family-reimbursement-application_3-27-23.pdf**
2. **PRINT OR WRITE LEGIBLY**
3. **Answer every applicable question. Failure to do so may result in your application being RETURNED or DENIED**

3A. Answer the Self Direction Question YES or NO -If yes, your application will not be accepted, we do not provide sports and recreation tickets or transportation services for individuals with self-direction services.

4. **SIGN and DATE the application**
5. **Incomplete applications will be returned**
6. **REQUIRED DATA on all applications:**
    - **You may submit a current Level of Care Eligibility (WITHIN ONE YEAR) Determination; or most recent complete psychological report (WITHIN THREE YEARS)**
    - **Name of person with developmental disabilities, i.e. the "applicant"**
    - **Date of birth, Social Security number, Medicaid number of the applicant and Tabs ID**
    - **Address of the applicant, complete with apartment number, borough and zip code**
    - **Name of person completing the application, relationship, address, and phone number(s)**
7. **NYSID services are funded by OPWDD Family Support funds. They are available only to individuals with developmental disabilities who live with their families and have OPWDD Eligibility.**
8. **WE WILL ACCEPT EMAILED or mail the application to the NYSID office in Staten Island**
9. **All applications are subject to approval, service/reimbursement is not guaranteed.**

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10. Applications requesting an evaluation must have a copy of an IEP, OPWDD request or a letter from a doctor requesting the evaluation.