Esperanza Center
516 West 181st Street, New York, N.Y.10033
212 - 928-5810

Family Reimbursement Program

__ CHECK HERE IF PRE-APPROVAL IS BEING REQUESTED (Note: Pre-approval is not necessary if services have already been provided or goods already purchased – just complete application and attach receipts.)

Name of person with disability: _____ Date of birth: _____

Check to be issued to: _____

Check to be sent to : _____ Apt #: ___ Zip Code: _____

What is being paid for? __ Service __ Goods

Amount paid (or if this is a pre-application, amount you expect to pay) $: _____

If you purchased an item please complete section below:

What goods are you requesting reimbursement for? _____

_____ Date of purchase: _____

Why was this purchase needed? _____

Name of the store where goods were purchased or will be purchased: _____

Have you applied for Family Reimbursement at any other agency? ___ Yes ___ No

If yes, name of agency: _____ Agency's phone number: _____

Agency's address: _____ Contact person: _____

DATED RECEIPT, SHOWING NAME AND ADDRESS OF THE STORE AND SIZE OF ITEMS IS REQUIRED.

Total amount or reimbursement requested _____

_____ _____

Signature Relationship to person with disability