Jeffrey A. Meyers
Commissioner

Deborah D. Scheetz
Director

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF LONG TERM SUPPORTS AND SERVICES

BUREAU OF DEVELOPMENTAL SERVICES

105 PLEASANT STREET, CONCORD, NH 03301
603-271-5034 1-800-852-3345 Ext. 5034
Fax: 603-271-5166 TDD Access: 1-800-735-2964 www.dhhs.nh.gov

Laconia State School Trust Fund – Non-Area Agency Request
(Revised 6-2019)

Name of individual requesting funds: _____

Was the individual a resident of Laconia State School? _____Yes ____No

If no, the individual is not eligible for funds

If yes, what time period did the individual reside at Laconia State School? _____

Reason for Reimbursement Request

Purpose	Amount Requested for Reimbursement	Has individual accessed the fund for this previously? If yes, how much did they access and when?	
Yearly Caps Apply (based on SFY)			
Transportation ($200/year)	_____	☐ Y ☐ N	Amount: _____ Date: _____
Clothing ($200/year)	_____	☐ Y ☐ N	Amount: _____ Date: _____
Home Equipment and Repair ($1,000/year)	_____	☐ Y ☐ N	Amount: _____ Date: _____
Education ($500/year)	_____	☐ Y ☐ N	Amount: _____ Date: _____
Lifetime Caps Apply			
Dental Work ($5,000/lifetime)	_____	☐ Y ☐ N	Amount: _____ Date: _____
Adaptive Durable Medical Equipment ($5,000/lifetime)	_____	☐ Y ☐ N	Amount: _____ Date: _____

Name: _____
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Amount Requested: _____

Name and address of payee (individual or vendor): _____

_____

I certify that the above reimbursement request is valid, there are no alternative funds to pay for the request (including Medicaid), this payment will not negatively affect any public benefits received by _____ and have **attached appropriate receipts**.

_____ _____
Signature of individual / guardian / representative Date

Developmental Services Approval

I have reviewed the reimbursement request and supportive documentation and I approve the request and certify that there are no alternative funds to pay for the request (including Medicaid). This payment will not negatively affect any public benefits received by the individual requesting funds.

_____ _____
Name & Signature of BDS Financial Administrator Phone # Date

_____ _____
Name & Signature of BDS Bureau Chief Phone # Date

Comments: