|  |  |
| --- | --- |
| **Lori A. Weaver**  **Commissioner**  **Melissa A. Hardy**  **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 4-2024)**

Name of individual requesting funds:

Was the individual a resident of Laconia State School?

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** –Submitted to **STATE PLAN** and received a Denial**?** If **No,** submit to STATE PLAN. If **Yes,** include the denial decision & fill out below **\*.** | **N/A** | Y N | Date: |
| **\* Adaptive Durable Medical Equipment** ($5,000/LSS lifetime) |  | Y N | Amount:  Date: |

Name:

Page 2

Amount Requested:

**Make Check Payable To:**

**Check Memo (Resident Name if not payee or other info as required or NA):**

**Mailing Address:**

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 of BDS Financial Administrator Signature Phone # Date

Name of Chief Operating Officer Signature Phone # Date

**Comments:**