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| **Jeffrey A. Meyers**  **Commissioner**  **Christine L. Santaniello**  **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**

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

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| **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 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 impact any public benefits I receive and I have attached appropriate receipts.

Signature of individual / guardian / representative Date

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 .

Signature of BDS Bureau Chief Date

Signature of BDS Financial Manager Date