Family Support Reimbursement Form

Applicant's Name: **Age:**
Name of person submitting this form: **Date submitted to the CDDO:**

Indicate who the check for reimbursement is to be made out to and mailed –
Parent/Guardian/Legal Representative Name(s):
Mailing address:
City, State, Zip:

Reimbursement is being requested for the following categories and amounts –
Maximum cap is $500 per year per child

Category	Mark if receipts and/or timesheets are attached	Total amount $
Personal needs including diapers/wipes/pull ups		
Respite		
Disability-related camp(s)		

Explanation of need:

If the CDDO needs additional information, who should we contact:
Name:
Email:
Phone:

Name of person submitting this form:
Signature: **Date:**