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**BOONE COUNTY FAMILY RESOURCES**

**REIMBURSEMENT REQUEST**

**For Toileting Supplies, Miscellaneous Family Supports, Assistive Technology, Developmental Disability Education Assistance**

|  |  |  |
| --- | --- | --- |
| **RESPONSIBLE PARTY NAME:** | **INDIVIDUAL NAME:** | **SUPPORT COORDINATOR:** |

|  |  |  |  |
| --- | --- | --- | --- |
| Date(s) of Purchase | Description of Purchase | Out of Pocket  Expense | Requested Reimbursement |
|  |  |  | $ |
|  |  |  | $ |
|  |  |  | $ |
|  |  |  | $ |
|  |  |  | $ |
|  |  |  | $ |
|  |  |  | $ |

**Please Attach the Following Required Documentation to Receive Reimbursement:**

|  |  |
| --- | --- |
|  | **Receipt and/or Documentation of Purchase** |

**TO RECEIVE REIMBURSEMENT, SUBMIT THE COMPLETED FORM WITH THE REQUIRED DOCUMENTATION ATTACHED VIA MAIL OR EMAIL TO THE SERVICE PROCUREMENT SPECIALIST BY THE 5TH OF THE MONTH.**

**REIMBURSEMENTS MAY BE DELAYED IF NOT SENT AS INDICATED BELOW:**

**To submit via mail or in person:**

Boone County Family Resources

**Attn: Service Procurement Specialist**

2700 West Ash

Columbia, MO 65203

**To submit via email:** [serviceprocurement@bcfr.org](mailto:serviceprocurement@bcfr.org)

**\*SUPPORT COORDINATORS CANNOT RECEIVE REIMBURSEMENT REQUESTS OR SUBMIT ON YOUR BEHALF\***

I/Our family understand and agree to follow the conditions for participation in the Reimbursement program on the reverse of this form. I/Our family have received and paid for the service(s) listed on this form and hereby request financial reimbursement. I hereby certify that I have not received reimbursement nor will I seek reimbursement for the service(s) elsewhere.

Responsible Party/Family Member Date

The Boone County Family Resources (BCFR) Reimbursement Program enables families to have more choices in selecting their service providers. Families can be reimbursed for payment to eligible providers who do not have a contract with our agency. If you have questions about our reimbursement program, please contact your Support Coordinator at 874-1995.

**CONDITIONS FOR PARTICIPATION IN THE REIMBURSEMENT PROGRAM**

*Read Carefully*

1. BCFR’s reimbursement is limited to services/supports prior authorized in the Agency's authorization system. If you have questions regarding the authorized amount, please contact your Support Coordinator prior to submitting Reimbursement Request.

2. You may submit reimbursement requests at any time during the authorized month, or within 90 days after the month of service. All required documentation must be fully completed and submitted together at the same time. Submit all dates of service together for a given month. Additional dates for the month will not be reimbursed after BCFR payment has been processed for that month.

3. Use this form to request reimbursement for:

Authorized Toileting Supplies

Authorized Miscellaneous Family Supports

Authorized Assistive Technology

Authorized costs, lodging, mileage for Development Disability Education Assistance

If you need additional copies of this form contact your Support Coordinator or see the BCFR website at: <https://www.bcfr.org/services/support-coordination/reimbursed-services/>

4. Please submit complete and accurate reimbursement requests via mail or email to the attention of the Service Procurement Specialist, at the address noted on the front of this page, by the 5:00 pm 5th of the month to allow for reimbursement by the 20th of that month. Any request received after the 5th of the month or that were not fully completed by the 5th of the month, payment will be sent by the 20th of the following month, once fully completed. If the 5th falls on a weekend or holiday of which the Agency is closed, submission of requests are due by 5:00 pm on the following business day.

5. Reimbursement from this agency will not exceed the established agency service limits, unit costs,

or authorized amount.

6. Complete this and other forms in ink. Please do not use correction fluid. Strike through any errors.