

**FAMILY CERTIFICATION FOR  
DISABILITY REIMBURSEMENT**

Name of Family member with disability: «full\_name»

I/We «reference name» certify that the above-named person is being provided with attendant care or the use of auxiliary apparatus to enhance his/her ability to live independently. The circumstance related to the cost of the care of apparatus are as follows:

- We do not receive reimbursement from any outside source such as insurance, Medicare, state grants, or individuals
- We are receiving reimbursement for portion of these costs from \_\_\_\_\_
- The cost of attendant care of auxiliary equipment is not paid to a family member living in our household.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Title