

Developmental Disabilities Services
Special Needs Autism
Payee Assurance

I/We _____ assure that if the Special Needs request for
(Name of Payee)
_____ is approved by DDS to purchase

Name of Service or Item(s)

(Initial all that apply)

_____ I will purchase the items, fees, deposits, or services only for the individual for whom the funds were approved.

_____ I will obtain receipts for any items, fees, deposits, or services that are equivalent to the amount received for the approved purchase and provide them to the DDS Service Coordinator.

(Name of Service Coordinator)

_____ I will ensure that all purchased items remain with the individual and/or the guardian, and may not be used by or for any other person or agency.

_____ I will return any unused balance of funds to DDS in the form of a check or money order made payable to DDS, identifying the recipient of funds and mailed to the Program Administrator, DDS, Slot S-380, PO Box 1437, Little Rock, AR 72203-1437.

I am aware that the Special Needs Autism funds is a special program available one time only. I am also aware that failure to abide by the terms of these assurances will cause DDS to disallow me from being a payee for any future regular Special Needs program requests.

Signed: _____
Payee

Date: _____

Signed: _____
DDS Service Coordinator

Date: _____

\$ _____
Amount Requested

\$ _____
Amount Approved (Initials/Date)