NEW YORK STATE DEPARTMENT OF HEALTH
Division of Long Term Care

Assistive Technology (AT) Description and Initial Cost Projection

Home And Community Based Services Medicaid Waiver
Nursing Home Transition and Diversion (NHTD) and Traumatic Brain Injury (TBI)

Check one: ☐ NHTD ☐ TBI

Applicant/Participant _____ (CIN) _____

1. Describe the Assistive Technology being requested.

2. Explain how the Assistive Technology will help contribute toward the applicant/participant's health and welfare.

3. Attach all assessments and bids. Identify the selected bid.

NOTE: a. If this is a rental property, a signed authorization from the landlord must be attached.

b. Other potential payment sources for the identified Assistive Technology including private insurance, community resources and other State/federal programs must be explored before a request for payment will be considered.

Applicant/Participant Signature _____ Date _____

Legal Guardian/Representative (if applicable) _____ Signature _____ Date _____

Assistive Technology Provider _____ Provider ID _____

Contact Person _____

Assistive Technology Supplier _____ Telephone Number _____

Service Coordinator _____

To be completed by the Regional Resource Development Specialist

☐ Approved ☐ Denied, Reason for denial _____

Regional Resource Development Specialist (RRDS) _____

RRDS Signature _____ Date _____

To be completed by DOH Waiver Staff

☐ Approved ☐ Denied, Reason for denial _____

DOH Waiver Staff (if over $35,000): _____

Signature _____ Date _____

NOTE: Cost projection form must be attached to the participant's Service Plan and/or Addendum