

Waiver Services Final Cost and Regional Resource Development Specialist (RRDS) Approval Of Final Cost

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 _____

Final cost for (Check one):

Initial Cost

Final Cost

**Note: Indicate if one-time
or an on-going expenditure.**

- | | | |
|--|----------|----------|
| <input type="checkbox"/> Assistive Technology (AT) | \$ _____ | \$ _____ |
| <input type="checkbox"/> Community Transition Services | \$ _____ | \$ _____ |
| <input type="checkbox"/> Moving Assistance (NHTD only) | \$ _____ | \$ _____ |

Provide an explanation if the final cost is not the same as the initial cost projection.

I acknowledge that the above Service was provided in accordance with the Service request.

Applicant/Participant Signature Date

Legal Guardian/Representative (if applicable) Signature Date

Service Coordinator Signature Date

Service Provider Signature Date

FOR RRDS USE ONLY

The final cost has been reviewed and is:

- Approved for the amount of \$ _____ Date of NOD _____
- Not approved because _____

RRDS Signature _____ Date _____

FOR DOH USE ONLY (to be completed only if DOH approval is required)

Note: DOH approval is required if the service exceeds the service cap.

- Approved for the amount of \$ _____
- Denied, reason for denial _____

DOH Staff _____ Signature _____ Date _____

Cc: Waiver Service Provider
Service Coordinator