MOVING ASSISTANCE DESCRIPTION AND COST PROJECTION

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

Applicant/Participant: _____CIN: _____

Current Address: _____

New Address: _____

1. Explain why the move is necessary.

2. How many times has this service been requested before or provided before? (Please be specific).

3. Moving company: _____Telephone:_____

Contact person:_____ NYSDOT License # (if applicable):_____
FMCSA License # (if applicable):_____

4. Total Moving Assistance funds requested, attach all estimates received. $ _____

Participant Signature: _____Date:_____

Service Coordinator: _____

Signature: _____Date: _____

Moving Assistance Provider: _____Provider ID#:_____

Contact Person: _____

Signature: _____

Regional Resource Development Specialist (RRDS): _____

Signature: _____Date: _____

☐ Approved ☐ Denied
Reason for denial:_____
_____
_____

DOH Waiver Management Staff (if over $5,000): _____

Signature: _____Date: _____