NEW YORK STATE DEPARTMENT OF HEALTH Division of Long Term Care	Change of Service Coordination Agency Request Home And Community Based Services Medicaid Waiver Nursing Home Transition and Diversion (NHTD) and Traumatic Brain Injury (TBI)	
□ NHTD □ TBI		
I, (Participant Name) request to make the following change in my I have been informed of my right to remain agency from a list of all available and appro	Service Coordination agency. with this current Service Coordination agend	
Current Service Coordinator Name and Telephone	Current Service Coordination Agency and Telephone	Requested Service Coordination Agency Name and Telephone
Participant Signature	Date	
Legal Guardian Signature (if applicable)		Date
Authorized Representative Signature (if applicable)		Date
Current Service Coordinator Signature		Date
Current Service Coordinator Supervisor Signature		Date
Service Coordinator/Agency Reason:	will n	rovide service(s) to the above named participant ot provide service(s) to the above named participant
Service Coordinator Signature		Date
Service Coordinator Supervisor Signature		Date
NOTE: The Regional Resource Development Requested Service Coordination Agency. To be completed by the the Regional Resou		vice Coordinator/agency and the newly
Regional Resource Development Center		
This request for change in Service Coordination Ag	gency has been reviewed and: Approved, service	es to begin effective:
Denied (explanation)		
Transition Meeting to be held on:	at AM / PM	
Regional Resource Development Specialist Signature		Date
cc: Participant Legal Guardian (if applicable) Authorized Representative (If applicable) Current Service Coordinator and/or Service Coordination New Service Coordinator and/or Service Coordination A All current Provider Agencies	in Agency Agency	