WAIVER SERVICES FINAL COST

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
TRAUMATIC BRAIN INJURY (TBI)

Applicant/Participant: _____CIN: _____

Final cost for: (Check One)
___ Assistive Technology ___Community Transition Services ___Environmental Modifications

1. Original Projected Cost $ _____ Final Cost $_____
   (if final cost is GREATER THAN 10% attach documentation of RRDS approval)

2. Describe the completed Service. (Attach itemized list and copies of receipts of all expenses incurred).

3. Justify any difference of less than 10% of the above original cost between the projected and final costs.

I certify that the above Service was provided in accordance with the above costs.

Waiver Service Provider Agency | Provider Medicaid #

Provider Address | Telephone

Provider Contact | Signature | Date

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

Service Coordinator | Signature | Date