

**HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER
FOR
NURSING HOME TRANSITION AND DIVERSION (NHTD)**

**NOTIFICATION OF DEATH OF A WAIVER PARTICIPANT
TO
LOCAL DEPARTMENT OF SOCIAL SERVICES**

Name & Address of Waiver Participant:

Client Identification Number (CIN): _____

Notice Date: _____

This is to inform you that the individual name above is discontinued from the Nursing Home Transition and Diversion waiver due to the death of the waiver participant on _____ (date).

Regional Resource Development Specialist (Signature)

Regional Resource Development Specialist (Print)

Name of Regional Resource Development Center (RRDC)

Address

Address

Telephone

cc: Service Coordinator
NYS DOH NHTD Waiver Program
Social Services District with fiscal responsibility
Social Services District in county of residence (If different from county of fiscal responsibility)