ASSISTIVE TECHNOLOGY DESCRIPTION AND COST PROJECTION

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

Applicant/Participant: ___________________________ CIN: ___________________________

1. Describe the Assistive Technology being requested.

2. Explain how the Assistive Technology will help contribute toward the applicant/participant's health and welfare.

3. Attach all assessments and bids. Identify the selected bid.
   NOTE: If this is a rental property, a signed authorization from the landlord must be attached.

Participant Signature: ___________________________ Date: __________
Assistive Technology Provider: ___________________________ Provider ID#: ____________________
Contact Person: ___________________________
Signature: ___________________________
Service Coordinator: ___________________________
Signature: ___________________________ Date: __________
Regional Resource Development Specialist (RRDS): ___________________________
Signature: ___________________________ Date: __________

☐ Approved
☐ Denied
Reason for denial: ___________________________

DOH Waiver Management Staff (if over $15,000): ___________________________
Signature: ___________________________ Date: __________