

WAIVER SERVICES FINAL COST

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

Applicant/Participant: _____ CIN: _____

Final cost for: (Check One)

Assistive Technology Community Transition Services Environmental Modifications
 Moving Assistance

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