DESCRIPTION AND COST PROJECTION FORM

Recipient Name: ___________________________________________ Medicaid CIN: ______________________

Request for: (Check One)  ☐ Assistive Technology  ☐ Environmental Modification  ☐ Vehicle Modification
☐ Community Transitional Services (CFCO only)  ☐ Moving Assistance (CFCO only)

1. Describe the service being requested.

2. Explain how the service will contribute to the recipient’s health and welfare.

3. Projected Cost $________________  Identify the selected bid.
   ☐ If the projected cost for the service will cause the aggregate calendar-year limit for that service to be exceeded, check here.

4. Attach all evaluations and bids.

5. For an E-Mod, if this is a rental property, a copy of the renter’s lease and signed permission from the landlord must be attached.

☐ For property that is owned by the individual or family, check box to indicate that proof of ownership was verified.

☐ For rented property, check box to indicate that the recipient attests that this is intended to be his/her long-term, primary residence.
Recipient Name: ___________________________ Medicaid CIN: ___________________________

Recipient Signature: ___________________________ Date: ____________

Legal Guardian/Representative (as applicable) Name: __________________________________________

Legal Guardian/Representative Signature: ___________________________ Date: ____________

Home or Vehicle Owner Name: ____________________________________________________________

Home or Vehicle Owner Signature: ___________________________ Date: ____________

Service Provider Name: _________________________________________________________________

Medicaid Provider ID# (as applicable): ___________________________

Contact Name: _________________________________________________________________

Contact Signature: ___________________________ Date: ____________

Care/Case Manager Name: _____________________________________________________________

Care/Case Manager Signature: ___________________________ Date: ____________

Modification/Purchase Approved:

Must submit a separate package for each modification/purchase.

☐ Assistive Technology ☐ Community Transitional Services

☐ Environmental Modification ☐ Moving Assistance

☐ Vehicle Modification

LDSS Representative Name: _____________________________________________________________

LDSS Representative Signature: ___________________________ Date: ____________
For LDSS only:
If you are requesting Special Project Voucher funding, please enter total project specific amount here and submit completed package to DOH through an option below.

Total Advance Requested $ ____________________

For DOH approval, please forward this form, its required documents and all supporting documentation from the checklist below:

☐ Evidence of valid Recipient Restriction Exception (RR/E) codes from eMedNY, e.g., screenshot of the recipient’s eligibility file in eMedNY

☐ Full Plan of Care (POC) or “Life Plan”

☐ Physician’s order supporting the service request

☐ Clinical justification provided by the appropriate clinician as per applicable service authorization guidelines

Fill out the following:

Have all other potential sources of payment been explored, including private insurance, community resources, and other State/federal programs? ☐ Yes ☐ No

Has recipient received/requested service before? ☐ Yes ☐ No

If yes, please provide details of service, i.e., when, where, why, final cost:

SUBMISSION – Securely submit this form and required supporting documentation via one of the secure methods below:

<table>
<thead>
<tr>
<th>Mail</th>
<th>Fax</th>
<th>HCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>NYS DOH/OHIP Division of Long Term Care Attn: CFCO-Children’s Approval Unit One Commerce Plaza, 16th Floor 99 Washington Avenue Albany NY, 12210</td>
<td>1-518-408-6045</td>
<td><a href="mailto:CFCO-ChildrensApproval@health.ny.gov">CFCO-ChildrensApproval@health.ny.gov</a></td>
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</tbody>
</table>

For NYSDOH use only

Tracking # ______________

Date Received: ___________ Date Reviewed: ___________ Reviewed By: ________________

For standard request: ☐ APPROVED ☐ NOT APPROVED

For request to exceed calendar year limit: ☐ APPROVED ☐ NOT APPROVED

Date letter of support sent to LDSS: ________________