NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Program

FINAL COST FORM

Recipient Name: ___________________________ Medicaid CIN: ________________

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

1. Original Projected Cost: $__________ Final Cost: $__________

2. Justify any difference of more than 10% above the original projected cost.

3. Describe the completed service. Attach itemized list of all expenses incurred along with copies of all receipts.

Provider Certification
I certify that the above service was provided in accordance with the above costs.

Service Provider/Agency: ___________________________ Provider Medicaid ID #: ________________

Provider Address: ___________________________ Telephone: ___________________________

Provider Contact Name: ___________________________
Provider Contact Signature: ___________________________ Date: ___________________________

Care/Case Manager Certification
I acknowledge that the above service was provided in accordance with the Person Centered Plan of Care.

Care/Case Manager Name: ___________________________
Care/Case Manager Signature: ___________________________ Date: ___________________________

Local Department of Social Services (LDSS) or Developmental Disabilities Regional Office (DDRO) Approval

LDSS or DDRO Signature: ___________________________ Date: ___________________________
Print Name: ___________________________

Submit to DOH using one of the secure options below:

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<thead>
<tr>
<th>Mail</th>
<th>Fax</th>
<th>HCS</th>
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<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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(Rev. 6/2019)