WAIVER SERVICES FINAL COST

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
TRAUMATIC BRAIN INJURY (TBI)

Applicant/Participant: ____________________________________________ CIN: __________________

Final cost for: (Check One)
___ Assistive Technology ___Community Transition Services ___Environmental Modifications

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 ____________