

**COMMUNITY TRANSITIONAL SERVICES (CTS) DESCRIPTION AND COST PROJECTION**  
**HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER**  
**TRAUMATIC BRAIN INJURY (TBI)**

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Referral #: \_\_\_\_\_

Applicant Name: \_\_\_\_\_ CIN: \_\_\_\_\_

1. Describe each component of the Community Transitional Services being requested and explain how the Community Transitional Services will contribute toward the applicant's re-entry into the community. (Apartments for which a security deposit is being requested must have a monthly rent within Fair Market Rate (FMR) if the applicant is seeking a housing subsidy from waiver.)
2. Describe the applicant's ability to make monthly rental payments and meet other costs for maintaining the dwelling (utility, heat, telephone).

3. Total CTS funds requested (from attached page 2) \$ \_\_\_\_\_

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Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Signature, if applicable: \_\_\_\_\_ Date: \_\_\_\_\_

CTS Provider: \_\_\_\_\_ Provider ID#: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Signature: \_\_\_\_\_

Service Coordinator: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Regional Resource Development Specialist (RRDS): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Approved

Denied

Reason for denial: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**COMMUNITY TRANSITIONAL SERVICES (CTS)  
DESCRIPTION AND COST PROJECTION (cont'd)**

**1. Funds needed to secure an apartment:**

Address: \_\_\_\_\_ Apartment #: \_\_\_\_\_

Landlord: \_\_\_\_\_ Telephone: \_\_\_\_\_

Landlord Address: \_\_\_\_\_

# of people sharing cost of residence: \_\_\_\_\_ Total Security Deposit: \$ \_\_\_\_\_ Please describe living situation: \_\_\_\_\_

Total monthly rent: \$ \_\_\_\_\_ CTS portion of security deposit \$ \_\_\_\_\_

**2. Utility Set-up**

Utility Company (Heating): \_\_\_\_\_ Account #: \_\_\_\_\_

# of people sharing residence: \_\_\_\_\_ Total Set-up Fee: \$ \_\_\_\_\_ CTS portion of Set-up Fee \$ \_\_\_\_\_

Utility Company (Electricity): \_\_\_\_\_ Account #: \_\_\_\_\_

# of people sharing residence: \_\_\_\_\_ Total Set-up Fee: \$ \_\_\_\_\_ CTS portion of Set-up Fee \$ \_\_\_\_\_

Utility Company (Phone): \_\_\_\_\_ Account #: \_\_\_\_\_

# of people sharing residence: \_\_\_\_\_ Total Set-up Fee: \$ \_\_\_\_\_ CTS portion of Set-up Fee \$ \_\_\_\_\_  
Total \$ \_\_\_\_\_

**3. Other Expenses**

Cleaning/Pest Control Company: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Purpose: \_\_\_\_\_

# of people sharing residence: \_\_\_\_\_ Total Set-up Fee: \$ \_\_\_\_\_ CTS portion of Fee \$ \_\_\_\_\_

Moving Company: \_\_\_\_\_ \$ \_\_\_\_\_  
Fee

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

**4. Total Cost**

Essential Household Furnishings (from Page 3) \$ \_\_\_\_\_

Amount

Total Community Transitional Services Requested \$ + \_\_\_\_\_

(not to exceed \$4,500 for NHTD and \$2,700 for TBI)

Administrative Fee for Community Transitional Services Provider \$ + \_\_\_\_\_

(10% of Total CTS Requested)

**TOTAL** \$ \_\_\_\_\_

**COMMUNITY TRANSITIONAL SERVICES (CTS)  
DESCRIPTION AND COST PROJECTION (cont'd)**

Essential Household Furnishings

Please list the requested items and the cost of each item. Applicants must explore all other available resources before applying for CTS funds. Only necessary household goods are covered by this service. Items **not** allowed include diversional or recreational items, such as televisions, VCR/DVDs or music systems.

<b>ITEM:</b>	<b>AMOUNT:</b>
Bathroom Set-Up	
Bed:	
Chair	
Chest of Drawers	
Cleaning Utensils	
Clock	
Coffee Table	
Couch	
Dishes, Bowls	
Fire Extinguisher	
First Aid Kit	
Kitchen Table and Chairs	
Lamps	
Light bulbs	
Linens	
Microwave	
Night Stand	
Pots, Pans and Kitchen Utensils	
Silverware	
Waste Baskets	
Window Blinds	
Other	

**TOTAL \$** \_\_\_\_\_  
(Transfer this amount to #4 Total Cost on Page 2)