NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Program

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: __________

Recipient Name:____ Medicaid CIN: ____________________

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:

Mail	Fax	HCS
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	1-518-408-6045	CFCO-ChildrensApproval@health.ny.gov

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: ____________