TBI/NHTD Housing Subsidy Prior Approval Request

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)
Traumatic Brain Injury (TBI)

Name: ____ Date: ________

Current Address: Region: _________________________________

___ Transition ___ Diversion

Service Coordinator Name: ______________________________________

County participant is seeking to reside in: _______________________________
FMR: $______________________ Number of Bedrooms: ___

Does the participant qualify for Community Transitional Services (CTS)? ____Yes ____No

Has housing been located? ____Yes ____No

If yes, what is the cost of rent per month? $________________

Anticipated move-in date: __________________

Will the participant require:

___ Broker's Fees Anticipated Cost: $________ attach Broker's Letter stating fees
___ Moving Expenses Anticipated Cost: $________
___ Household Goods Anticipated Cost: $________
___ Security Anticipated Cost: $________
___ Utility Anticipated Cost: $________
___ Deposit/Application Fee Anticipated Cost: $________

What other housing support resources have been explored or are being explored:

e.g. ___ Olmstead Outcome: ________________________________
___ Violent Crimes Outcome: ________________________________
___ Emergency Funds (LDSS) Outcome: ________________________________

Anticipated cost of request: $____________ Initial $____________ Monthly

Provide a brief justification for the request:

Approved ____ Yes ____ No

____ __________
Maribeth Gnozzio, Division of Long Term Care Date