

NHTD     TBI

Home And Community Based Services Medicaid Waiver  
Nursing Home Transition and Diversion (NHTD) and Traumatic Brain Injury (TBI)

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I, \_\_\_\_\_ have been informed that I may be eligible for services provided through either a nursing facility or a Home and Community Based Services Medicaid Waiver.

**Check One:**

- I have chosen to apply for the Nursing Home Transition and Diversion or Traumatic Brain Injury Medicaid Waiver.
- I have chosen to apply for Medicaid State Plan Services and/or another Home and Community Based Services Medicaid Waiver.
- I have chosen **NOT** to apply for services through a Home and Community Based Services Medicaid waiver at this time.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Legal Guardian Name (as applicable)

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorized Representative (as applicable)

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Regional Resource Development Specialist

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date