NEW YORK STATE DEPARTMENT OF HEALTH
Division of Long Term Care

Change of Provider Request

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

Check one: ☐ NHTD ☐ TBI

I, (Participant Name) _____ (CIN) _____
request to make the following change in waiver service provider agency and/or the agency staff currently providing this service to me.

I have been informed of my right to remain with this current waiver service provider agency or select a new agency from a list of all available Waiver Service Providers for this service.

Waiver Service	Current Provider Agency Name or Provider Agency Staff Name and Telephone	Requested Provider Agency Name or Provider Agency Staff Name and Telephone

Participant Signature _____ Date _____

Legal Guardian Signature (if applicable) _____ Date _____

Authorized Representative Signature (if applicable) _____ Date _____

NOTE: Service Coordinator must notify Current and Requested Provider of this Request.

Current Service Coordinator Signature _____ Date _____

Agency Name _____

Transition Meeting to be held on (mm/dd/yyyy): _____ at _____ AM/PM

To be completed by the Requested Provider:

_____
Provider/Provider Agency

☐ **will provide** service(s) to the above named participant
☐ **will not provide** service(s) to the above named participant

Reason: _____

_____
Provider Contact Signature/Title _____ Date

To be completed by the the Regional Resource Development Specialist:

This request for change in waiver Provider and/or waiver Provider Agency has been reviewed and:

☐ Approved, services to begin effective: _____

☐ Denied (explanation) _____

_____
Regional Resource Development Specialist Signature _____ Date

cc: Participant
Legal Guardian (if applicable)
Current Waiver Service Provider
New Waiver Service Provider
All current Provider Agencies