NEW YORK STATE DEPARTMENT OF HEALTH
Division of Long Term Care

Moving Assistance Description and Initial Cost Projection

Home And Community Based Services Medicaid Waiver
Nursing Home Transition and Diversion (NHTD)

Applicant/Participant _____ (CIN) _____

Current Address _____

New Address _____

1. Explain why the move is necessary.

2. How many times has this service been requested before or provided before? (Please be specific).

3. Name of Moving Assistance Provider _____ Provider ID _____

Contact Person _____ Telephone Number _____

NYSDOT License # (if applicable) _____ FMCSA License # (if applicable) _____

4. Total Moving Assistance funds requested, attach all bids received.

Identify the selected bidder and amount:

Selected Bid _____ $ _____ Amount

To be completed by the the Regional Resource Development Specialist:

☐ Approved

☐ Denied, Reason for denial _____

Regional Resource Development Specialist Signature _____ Date _____