NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Program

FINAL COST FORM

Recipient Name:_____ Medicaid CIN:_____

Final cost for (Check One): ☐Assistive Technology ☐Environmental Modification ☐Vehicle Modification

☐Community Transitional Services (CFCO only) ☐Moving Assistance (CFCO only)

1. Original Projected Cost: $_____ Final Cost: $ _____

2. Justify any difference of more than 10% above the original projected cost.

3. Describe the completed service. Attach itemized list of all expenses incurred along with copies of all receipts.

Provider Certification

I certify that the above service was provided in accordance with the above costs.

Service Provider/Agency:_____ Provider Medicaid ID #: _____

Provider Address:_____ Telephone:_____

Provider Contact Name: _____

Provider Contact Signature:_____ Date: _____

Care/Case Manager Certification

I acknowledge that the above service was provided in accordance with the Person Centered Plan of Care.

Care/Case Manager Name: _____

Care/Case Manager Signature:_____ Date:_____

Local Department of Social Services (LDSS) or Developmental Disabilities Regional Office (DDRO) Approval

LDSS or DDRO Signature:_____ Date: _____

Print Name: _____

Submit to DOH using one of the secure options 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

(Rev. 6/2019)