Consent and Approval

DESCRIPTION AND COST PROJECTION FORM

This section to be completed by the HHCM/C-YES:

Recipient Name:_____Medicaid CIN: _____

Request for: (Check One) ☐ Assistive/AdaptiveTechnology ☐ Environmental Modification ☐ Vehicle Modification

1. Describe the project/request.

2. Explain how the project/request will contribute to the recipient's health and welfare.

3. A) Estimated Project Cost $_____Identify the selected bid: _____
   B) Evaluation Cost (pre-project evaluation, scope of project, architectural drawings/renderings): $_____
   C) Assessment Cost (clinical justification, behavioral analysis, driver assessment, training costs): $_____
   D) Estimated Project Management Cost (if applicable): $_____
   E) Estimated Post-Project Evaluation Cost: $_____
   F) Estimated Total Project Cost (including project cost + evaluations + assessments + project management costs): $_____

☐ If the estimated project cost will exceed the annual soft cap or the aggregate calendar year limit for the request type, check here.

For an **EMod:**
☐ For property that is owned by the individual or family, check box to indicate that proof of ownership was verified. Signed permission from the property owner must be obtained
☐ For rented property, check box to indicate that the recipient attests that this property is intended to be his/ her long-term, primary residence.
☐ Signed permission from the landlord to install/modify the property is provided.

For a **VMod:**
☐ For a vehicle that is owned by the individual or family, check box to indicate that proof of ownership was verified. Signed permission from the vehicle owner must be obtained.
☐ Check box to confirm that the vehicle being modified is less than 5 years old, has less than 50,000 miles, and is registered, inspected, and in good working order.

For **AT:**
☐ Check box to verify that this request cannot be classified as Durable Medical Equipment (DME).

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Recipient Name:_____ Medicaid CIN: _____

Recipient Signature:_____ Date: _____

Legal Guardian/Legally Authorized Representative (as applicable) Name: _____

Legal Guardian /Legally Authorized Representative Signature:_____ Date: _____

Home or Vehicle Owner Name: _____

Home or Vehicle Owner Signature:_____ Date: _____

Project Management Business Name: _____

Contact Name: _____

Contact Signature: _____ Date: _____

Care Management Agency Name: _____

HHCM/ C-YES Name: _____

HHCM/C-YES Signature: _____ Date:_____

DESCRIPTION AND COST PROJECTION FORM

Recipient Name:_____Medicaid CIN: _____

This section to be completed by the LDSS:

Have all other potential sources of payment been explored, including private insurance, community resources, and other State/federal programs? ☐Yes ☐No

Has recipient received/requested service before? ☐Yes ☐No

*If yes, please provide details of service, i.e., when, where, why, final cost:

Modification/Request Approved:

**Must submit a separate application for each modification/request.*

☐Assistive Technology

☐Environmental Modification

☐Vehicle Modification

LDSS Representative Name: _____County: _____

LDSS Representative Signature: _____Date: _____

LDSS Contact Information:

Phone Number: _____

Email Address: _____

Please forward this form, current Plan of Care, Evidence of valid Recipient Restriction Exception (RR/E) codes from eMedNY, all required documents, and supporting documentation to NYSDOH review:

SUBMISSION – Securely submit this form and required supporting documentation via secure email: EModVModAT@health.ny.gov