FINAL COST FORM

Recipient Name:_____Medicaid CIN:_____

(Check One): ☐Assistive/Adaptive Technology ☐Environmental Modification ☐Vehicle Modification

1. Describe the completed project/request. Attach itemized list of all expenses incurred along with copies of all receipts.

2. Please identify the following RF17 reference information associated with each payment:
   - Claim Effective Date
   - Package Type
   - Sequence Number

3. Original Projected Project Cost/Bid: $_____
   Cost of Evaluation/Assessments: $_____
   Actual Final Cost of Project (Including Evaluations/Assessments): $_____

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

Project Evaluator Certification

I certify that the above project was completed in accordance with the scope of project or approved request.

Evaluator Business Name: _____

Evaluator Address: _____ Telephone: _____

Evaluator Contact Name: _____

Evaluator Signature: _____ Date: _____

Provider/Contractor Certification

I certify that the above project was completed in accordance with the scope of project or approved request.

Provider/Contractor Business Name:_____

Provider/Contractor Address:_____Telephone:_____

Provider/Contractor Contact Name: _____

Provider/Contractor Contact Signature:_____Date: _____

Parent/Guardian Attestation

I attest that the above project was completed or provided in accordance with the approved request.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

FINAL COST FORM

HHCM/C-YES Attestation

I attest that the above project was completed or provided in accordance with the identified member need in their current Plan of Care.

Care Management Agency: _____

HHCM/C-YES Name: _____

HHCM/C-YES Signature:_____Date:_____

Local Department of Social Services (LDSS) Approval

LDSS Signature:_____Date: _____

Print Name: _____ County: _____

Submit completed form and invoices to DOH using secure email: EModVModAT@health.ny.gov