Children's Waiver
Environmental/Vehicle Modification and Assistive/Adaptive Technology

PRE-PROJECT EVALUATION PAYMENT REQUEST FORM

Recipient Name: _____ **Medicaid CIN:** _____

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

Describe the proposed project/request: _____

_____

_____

Evaluator Information

Evaluator Business Name: _____

Evaluator Contact Name: _____

Evaluator Phone: _____ Email: _____

Signature of Evaluator: _____ Date: _____

Evaluation Information

Type of Evaluation: _____

Pre-Project Evaluation Cost: $_____

Date of Pre-Project Evaluation: _____

Address of Pre-Project Evaluation: _____

Evaluation Acknowledgement and Approval

Name of HHCM/CYES: _____CMA: _____

Signature of HHCM/C-YES: _____Date: _____

_____

☐ **By checking this box, the LDSS confirms approval of this evaluation**

LDSS Representative Name: _____County: _____

Signature of LDSS Representative: _____ Date: _____

SUBMISSION – Submit this form along with the pre-project evaluation and/or associated invoice(s) via secure email to EModVModAT@health.ny.gov