NEW YORK STATE DEPARTMENT OF HEALTH
Division of Long Term Care

☐ NHTD ☐ TBI

Provider Selection

Home And Community Based Services Medicaid Waiver
Nursing Home Transition and Diversion (NHTD) and Traumatic Brain Injury (TBI)

NOTE:
This form must be returned to the Service Coordinator to complete Provider Selection process. Services may not begin until final notification by Service Coordinator is received.

I understand that as an applicant/participant for the above indicated waiver, I must select a Provider(s) from the attached list of approved Waiver Service Provider Agencies. I have been encouraged to interview the Provider(s) prior to making my selection. I understand that the Provider(s) will assist me with the development and implementation of a Detailed Plan which reflects my wishes and needs, maintains my health and welfare, and monitors the provision of services for quality and appropriateness.

I also understand that at any time I may change my Provider Agency and still be eligible for the waiver.

From the approved Provider Agency list, I have chosen:

Name of Provider Agency _____ Telephone _____

Provider Address _____

From this Provider agency, I am requesting the following services:

1. HCSS 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Applicant Name _____

Applicant Signature _____ Date _____

Applicant Address _____

Legal Guardian Signature (if applicable) _____ Date _____

Authorized Representative Signature (if applicable) _____ Date _____

To be completed by Provider Agency:

Provider Agency _____ signature _____ date _____

☒ will provide all of the above listed services ☐ is unable to provide the following service(s):

Because: participant choice

☐ will not provide any of the above listed services

Because: _____

Service Coordinator Signature _____ Date _____

Regional Resource Development Specialist Signature _____ Date _____