Molina Helathcare of New York, Inc.
Please Fax to 1-866-879-4742

DESCRIPTION AND COST PROJECTION FORM

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

Request for: (Check One)

- ☐ Assistive Technology
- ☐ Environmental Modification
- ☐ Vehicle Modification

1. Describe the project/request.

2. Explain how the service will contribute to the recipient's health and welfare.

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): $ _____

☐ **CHECK HERE** if the projected cost for the service will cause the aggregate calendar year limit for that service to be exceeded.

3. Attach all evaluations and bids.

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.

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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/Representative (as applicable) Name: _____

Legal Guardian/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: _____

Modification/Purchase Approved:

Must submit a separate package for each modification/purchase.

☐ Assistive Technology

☐ Community Transitional Services

☐ Environmental Modification

☐ Moving Assistance

☐ Vehicle Modification

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

Fill out the following:

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

If yes, please provide details of service (when, where, why, final cost, etc.):

SUBMISSION – Securely submit this form and required supporting documentation via Fax at 1-866-879-4742