TBI/NHTD Housing Subsidy Prior Approval Request

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER

☐ **Nursing Home Transition and Diversion (NHTD)**

☐ **Traumatic Brain Injury (TBI)**

Name: _____ Date: _____

Current Address: Region: _____

☐ Transition ☐ Diversion

Service Coordinator Name: _____

County participant is seeking to reside in: _____

FMR: $_____ Number of Bedrooms: ___

Does the participant qualify for Community Transitional Services (CTS)? ☐ Yes ☐ No

Has housing been located? ☐ Yes ☐ No

If yes, what is the cost of rent per month? $_____

Anticipated move-in date: _____

Will the participant require:

- ☐ Broker's Fees — Anticipated Cost: $_____ attach Broker's Letter stating fees
- ☐ Moving Expenses — Anticipated Cost: $_____
- ☐ Household Goods — Anticipated Cost: $_____
- ☐ Security — Anticipated Cost: $_____
- ☐ Utility — Anticipated Cost: $_____
- ☐ Deposit/Application Fee — Anticipated Cost: $_____

What other housing support resources have been explored or are being explored:

e.g.
- ☐ Olmstead — Outcome: _____
- ☐ Violent Crimes — Outcome: _____
- ☐ Emergency Funds (LDSS) — Outcome: _____

Anticipated cost of request: $_____ Initial $_____ Monthly

Provide a brief justification for the request:

Approved ☐ Yes ☐ No

_____ _____

Maribeth Gnozzio, Division of Long Term Care Date