New York State Department of Health
Division of Home and Community Based Services

CHANGE OF PROVIDER REQUEST

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVERS
TRAUMATIC BRAIN INJURY (TBI)

I, (Participant Name)_____ (CIN) _____ request to make the following change in waiver service provider agency and/or the agency staff currently providing this service to me.

I have been informed of my right to remain with this current waiver service provider agency or select a new agency from a list of all available Waiver Service Providers for this service.

Waiver Service	Current Provider Agency Name or Provider Agency Staff Name and Telephone	Requested Provider Agency Name or Provider Agency Staff Name and Telephone

_____
Participant Signature Date

_____
Legal Guardian Signature (as applicable) Date

_____
Authorized Representative Signature (as applicable) Date

NOTE: SERVICE COORDINATOR MUST CONTACT CURRENT AND REQUESTED PROVIDER OF THIS REQUEST.

_____
Current Service Coordinator Signature Agency Name Date

Transition Meeting to be held on: _____/_____/20____ at _____am / pm

To be completed by the Requested Provider:

_____ _____ will provide service(s) to the above named participant
Provider / Provider Agency _____ will not provide service(s) to the above named participant
Reason: _____

_____

_____
Provider Contact Signature/Title Date

To be completed by the Regional Resource Development Specialist:

This request for change in waiver Provider and/or waiver Provider Agency has been reviewed and:

☐approved Services to begin effective ____/____/___

☐denied (explanation): _____

_____
Regional Resource Development Specialist Signature Date

cc: Participant
Legal Guardian (if applicable)
Authorized Representative (If applicable)
Current Waiver Service Provider
New Waiver Service Provider
All current Provider Agencies