NEW YORK STATE DEPARTMENT OF HEALTH
Division of Long Term Care

☐ NHTD ☑ TBI

Freedom of Choice

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

I, _____ have been informed that I may be eligible for services provided through either a nursing facility or a Home and Community Based Services Medicaid Waiver.

Check One:

☐ I have chosen to apply for the Nursing Home Transition and Diversion or Traumatic Brain InjuryMedicaid Waiver.

☐ I have chosen to apply for Medicaid State Plan Services and/or another Home and Community Based Services Medicaid Waiver.

☐ I have chosen **NOT** to apply for services through a Home and Community Based Services Medicaid waiver at this time.

Applicant Signature		Date
Legal Guardian Name (as applicable)	Applicant Signature	Date
Authorized Representative (as applicable)	Applicant Signature	Date
Regional Resource Development Specialist	Applicant Signature	Date