COMMUNITY TRANSITIONAL SERVICES (CTS) DESCRIPTION AND COST PROJECTION

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

Referral #: _____

Applicant Name: _____ CIN: _____

1. Describe each component of the Community Transitional Services being requested and explain how the Community Transitional Services will contribute toward the applicant's re-entry into the community. (Apartments for which a security deposit is being requested must have a monthly rent within Fair Market Rate (FMR) if the applicant is seeking a housing subsidy from waiver.)

2. Describe the applicant's ability to make monthly rental payments and meet other costs for maintaining the dwelling (utility, heat, telephone).

3. Total CTS funds requested (from attached page 2) $ _____

Applicant Signature: _____ Date: _____

Guardian Signature, if applicable: _____ Date: _____

CTS Provider: _____ Provider ID#: _____

Contact Person: _____

Signature: _____

Service Coordinator: _____

Signature: _____ Date: _____

Regional Resource Development Specialist (RRDS): _____

Signature: _____ Date: _____

☐ Approved ☐ Denied

Reason for denial: _____

_____

_____

COMMUNITY TRANSITIONAL SERVICES (CTS)
DESCRIPTION AND COST PROJECTION (cont'd)

1. Funds needed to secure an apartment:

Address: _____Apartment #: _____

Landlord: _____Telephone: _____

Landlord Address: _____

# of people sharing cost of residence:_____ Total Security Deposit: $_____ Please describe living situation: _____

_____

Total monthly rent: $_____ **CTS portion of security deposit** $_____

2. Utility Set-up

Utility Company (Heating): _____ Account #: _____

# of people sharing residence:____ Total Set-up Fee:$____ **CTS portion of Set-up Fee** $_____

Utility Company (Electricity):_____ Account #: _____

# of people sharing residence:____ Total Set-up Fee:$____ **CTS portion of Set-up Fee** $_____

Utility Company (Phone): _____ Account #: _____

# of people sharing residence:____ Total Set-up Fee:$____ **CTS portion of Set-up Fee** $_____

Total $_____

3. Other Expenses

Cleaning/Pest Control Company: _____

Address: _____Telephone:_____

Purpose: _____

# of people sharing residence:____ Total Set-up Fee:$____ **CTS portion of Fee** $ _____

Moving Company: _____ $ _____
Fee

Address: _____Telephone:_____

4. Total Cost

Essential Household Furnishings (from Page 3) $ _____
Amount

Total Community Transitional Services Requested $ +_____
(not to exceed $4,500 for NHTD and $2,700 for TBI)

Administrative Fee for Community Transitional Services Provider $ +_____
(10% of Total CTS Requested)

TOTAL $ _____

COMMUNITY TRANSITIONAL SERVICES (CTS)
DESCRIPTION AND COST PROJECTION (cont'd)

Essential Household Furnishings

Please list the requested items and the cost of each item. Applicants must explore all other available resources before applying for CTS funds. Only necessary household goods are covered by this service. Items **not** allowed include diversional or recreational items, such as televisions, VCR/DVDs or music systems.

ITEM:	**AMOUNT:**
Bathroom Set-Up	
Bed:	
Chair	
Chest of Drawers	
Cleaning Utensils	
Clock	
Coffee Table	
Couch	
Dishes, Bowls	
Fire Extinguisher	
First Aid Kit	
Kitchen Table and Chairs	
Lamps	
Light bulbs	
Linens	
Microwave	
Night Stand	
Pots, Pans and Kitchen Utensils	
Silverware	
Waste Baskets	
Window Blinds	
Other	

TOTAL $_____
(Transfer this amount to #4 Total Cost on Page 2)