NEW YORK STATE OF OPPORTUNITY. | Office for People With Developmental Disabilities

APPLICATION FOR PARTICIPATION IN THE
OPWDD HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVER

Name of Applicant: _____

Current Address: _____

_____

Social Security #: _____ Date of Birth: _____

Medicaid #: _____ County: _____

☐ Check here if not currently enrolled in Medicaid.

I am requesting participation in the Home and Community Based Services Waiver administered by the New York State Office for People With Developmental Disabilities. I understand that approval will be based on my choice of Home and Community Based Services in preference to care in an Intermediate Care Facility and on evidence of:

- developmental disability;
- eligibility for admission to an Intermediate Care Facility;
- eligibility for Medicaid enrollment;
- selection of a care management provider;
- availability of appropriate community based services; and
- appropriate living arrangement.

Date of stated intent to apply for HCBS waiver services: _____

Applicant Signature: _____

Applicant Name (Print): _____

Assisted by (Signature): _____

Assisted by (Print): _____

Assisted by Address: _____

_____

Telephone Number: _____ Date: _____

Revised 9/18/2018