DOWN PAYMENT COST FORM

Recipient Name: _____

Medicaid CIN# _____

Down Payment cost for (Check One):

- ☐ Assistive Technology
- ☐ Environmental Modification
- ☐ Vehicle Modification
- ☐ Community Transitional Services (CFCO only)
- ☐ Moving Assistance (CFCO only)

1. Original Projected Cost: $ _____ Down Payment Cost: $ _____
2. Justify any difference of more than 10% above the original projected cost.
3. Down payment amount requested _____
4. Down payment date of service _____
5. Email completed form to MHNYProviderContracting@MolinaHealthcare.com

Provider Certification

I certify that the above service was provided in accordance with the above costs.

Service Provider/Agency: _____ Provider Medicaid ID #: _____

Provider Address: _____ Telephone: _____

Provider TIN: _____

Provider Contact Name: _____

Provider Contact Signature: _____ Date: _____

Case Manager Certification

I acknowledge that the above service was provided in accordance with the Person-Centered Plan of: Care. Care/Case Manager

Name: _____

Care/Case Manager Signature: _____ Date: _____

Signature: _____