Department of Health and Social Services
Division of Senior and Disabilities Services

REQUEST FOR COST ESTIMATE: BLANK

To: Environmental Modification Service Provider:
Provider #:

From: Care Coordinator:
Care Coordination Agency:
Phone Number:
Fax:
Email:

Re: Recipient:
Street Address:
City, State, Zip Code:
Phone Number:
Email:

COST ESTIMATE DUE PRIOR TO _____, 5:00 PM

CONTRACTOR: Please complete this cost estimate sheet and fax it to the above number. Completion of all items of this cost estimate is required for approval.

COST ESTIMATE SCOPE OF WORK:

1. All environmental modifications must meet the 1998 Americans with Disabilities Act Accessibility Guidelines. Please document within this cost estimate form, any reasons the 1998 Americans with Disability Act Accessibility Guidelines cannot be complied with.

Contractors are encouraged to obtain before, during and completion photographs.

COST ESTIMATE SUMMARY: Please attach an itemized list containing a breakdown for each of the following cost estimate categories.

Demolition Cost:
Materials and Equipment (list items):
Labor:
Specify Fees:
List Permits Required:

COST ESTIMATE TOTAL:

Administrative Fee: $50.00 or 2% of the total cost
(Note: an administrative fee is authorized for HC Agencies only.)

PROJECTED START DATE:

ESTIMATED COMPLETION DATE:

SUBMITTED BY:

Company Name:
Street Address:
Phone Number:
Name:
Title:
List License Type:
Email:

Statement: If approved, I agree to perform the work of this environmental modification as specified in the scope of work, cost estimate summary and itemized list of cost estimate categories. I further agree that no changes are made to this work without approval of the Division of Senior and Disabilities Services.

Signature Date/Time: