Date Requested:
Date Received:

Assistive Technology Fund Application

NEW MEXICO DEPARTMENT OF HEALTH

Mail to:
Assistive Technology Project
PO Box 1269
Los Lunas, NM 87031
(505) 841-5287 or (800) 283-8415
AT.Coord@state.nm.us

Individual's Name:	**Contact Person:**	**Personal Funds Available? Yes ☐ No ☐**
Address:	**Phone:**	**Medicare/Medicaid/Salud Funding**
	Make check payable to:	**Requested: Yes ☐ No ☐ N/A ☐**
Phone: DOB:	**Address:**	**Status: Denied ☐ Accepted ☐**
Jackson Class Member: Yes ☐ No ☐	**Phone:**	**Therapists discussed AT needs? Yes ☐ No ☐**

Explanation of need and proposed plan: (Attach additional explanation if needed)

Signature: Date:

Amount requested and explanation of costs not to exceed $250 per individual per fiscal year:(Please list each cost including shipping & handling, please attach a photocopy of catolog page for items if possible). No tax can be paid.

Quantity	Description	Price	S/H
	Grand Total:		

For Business Use Only:

Clinical Review:
Approved: Yes ☐ No ☐ Amount Approved: Signature: Date:
AAC ☐ ADL ☐ COMP ☐ ECU ☐ LSR ☐ MOB ☐ POS ☐ SWOP ☐ SWTCH ☐