DD WAIVER (BUDGET-BASED) ASSISTIVE TECHNOLOGY FUND (ATF) APPLICATION

Please include ALL information requested!

Name: _____ ISP Dates: From:_____ To: _____ DOB: _____
☐ **Initial Application OR** ☐ **Revision (due to change in cost/change in request)**
☐ **Includes request for funds from other programs: _____** ***(Appendix K exception, etc.)***

DDW AT FUND (ISP Year) requests are submitted to Case Manager for any person on DD Waiver.

[1] **Person's address:**	[2] **Contact Person (individual completing this application - if different from the recipient)** **Name:** **Phone:** **E-mail:**	[4] **DO NOT use this form if a person receives services from:** **Medically Fragile Waiver** **Mi Via Waiver** **Supports Waiver**
City/State/Zip:	[3] ☐ **Check if Contact Person will purchase & deliver items approved. Cannot be guardian. Delivery information for funds.**	[5] ***Other funding considerations:*** ☐ **IDT/Therapists have discussed/prioritized AT funding needs.**
Home phone (if items are being sent directly to recipient):	**Mailing Address:**	☐ **Other funding sources were explored and are not available for requested items (Insurance/MCO, DVR, warranty replacement, IDEA).** *See instructions on page 3.*
	City/State/Zip:	
[6] **Case Manager Name:**		**Date reviewed by IDT/CM/responsible party:**

Background information / Plan for the use of requested AT (attach additional page for explanation, if needed):

[7] **Please check each box to indicate that the purchase of AT equipment meets the funding criteria listed below.**

☐ The AT items will be used during performance of a functional activity.
☐ The AT has a specific adaptation or feature that assists or compensates for a person's disability.
☐ If the AT item has a sensory stimulation component check the following boxes. ☐ N/A no sensory stimulation component
  ☐ This AT is NOT used primarily for sensory stimulation *and*
  ☐ This AT item IS related to a therapy plan/TDF/ISP goal/outcome
☐ This AT request does not exceed the funding limit of a total of $50.00 worth of batteries during the current ISP cycle.
☐ Amount requested does not exceed $500.00 per individual, inclusive of 15% purchasing agent fee, per fiscal year. If cost exceeds $500.00, the requestor must identify supplemental funding source(s) on p.2.
☐ The AT will be used primarily outside of therapy sessions and will NOT be used only toward performing a therapeutic activity, i.e., increasing range of motion.
☐ This AT request is NOT for educational or business purposes.
☐ This AT request is a software application for a device and is related to functional goals. ☐ N/A not a software application
☐ This AT will NOT be used to PREPARE an individual to engage in a functional activity.
☐ This AT item/service funding request does NOT include any items or activities that are prohibited by federal, state or local statutes and standards.
☐ If the AT item is being sold as 'refurbished', the Guardian has approved of this purchase. ☐ N/A not refurbished
☐ This AT supports these ISP Visions/Outcomes:

Brief explanation of why any criteria item is NOT checked:

[8] **Relevant diagnosis(es) and functional limitations related to the AT equipment being requested:**

[9] **Justification Statement: What functional activities will be supported by this AT equipment and what adaptation or features of the requested AT items will assist the person to participate in functional/meaningful daily activities?**

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Please include ALL information requested!

Name: _____ ISP Dates: From:_____ To: _____ DOB: _____

☐ **Initial Application OR** ☐ **Revision (due to change in cost/change in request)**

☐ **Includes request for funds from other programs: _____** ***(Appendix K exception, etc.)***

Please include ALL information requested in the table(s) below!

[10] ***Include weblink for each specific item in table below. If weblink is not included, a PDF or photocopy of item/catalog page with item number must be attached!***

Quantity	Item specific weblink	Item name, item number, and descriptors	Price each	Total per item
			subtotal	
			S/H (if applicable)	
			taxes	
			Total	

Quantity	Item specific weblink	Item name, item number, and descriptors	Price each	Total per item
			subtotal	
			S/H (if applicable)	
			taxes	
			Total	
Attach additional pages if needed.				

[11] **AT Item Total - Sum of all items above**	
[12] ◉ AT Provider Agency is the **Purchasing Agent** of the AT items being requested Purchasing Agent Fee: Sum of AT Request Total multiplied by 15% *(max = $75.00 see instructions)* ex. if AT total is $200.00 multiplied by 15%, purchasing Agent Fee is $30.00	
OR	
○ AT Provider Agency/Vendor is the **Direct Provider** of the AT items being requested	**N/A**
[13] **AT Fund Request Grand Total ****	

[14] ** If the AT Fund Request Grand Total exceeds $500.00, indicate the source of additional funds being used to complete purchase _____

There may be exceptions if another funding source such as Appendix K is being utilized (according to other source guidelines).

Receipts and any remaining monies must be forwarded to the Purchasing Agent within 30 days of purchase!
Contact Purchasing Agent directly for current fund adjustment process.

[15] **Date this application forwarded to Case Manager:**

ATF Purchasing Agent (PA) Section Only	
Date ATF-app received:	
Signature:	Date:
Date AT ordered by PA or Date check sent to contact person:	
Date AT item(s) received by individual:	
Date receipt for purchase received from requestor:	

DD WAIVER (BUDGET-BASED) ASSISTIVE TECHNOLOGY FUND (ATF) APPLICATION

Please include ALL information requested!

USE THIS APPLICATION FORM FOR: any person on DD Waiver.

1. Person completing the form fills out the header with name, ISP dates, DOB
2. Check if this form is an Initial Application OR a Revision
3. Check if this form includes a request for funds from other programs (ex. Appendix K exception)

Item 1: Enter the person's address and home phone.

Item 2: Contact Person: enter the name, phone, and email for the person completing the application.

Item 3: Check if the funds being requested will be sent to the contact person (rather than to the recipient's home address). If the box is checked: enter the contact person's *mailing address* that is safe for receiving the check. Note: Funds cannot be given directly to the guardian.

Item 4: Do not submit this form if the person receives services from Medically Fragile Waiver, Mi Via Waiver, Supports Waiver, or is less than 18 years of age. Please use alternate waiver-specific forms.

Item 5:

5a. It is required that IDT members discuss and prioritize AT funding needs before submitting this application. Check the box to confirm this process has been followed.

5b. It is required that IDT members explore other funding options before submitting this application. Check the box to confirm this process has been followed.

Attach documentation (denial letter or similar) to indicate proof of denial or non-covered benefit from insurance/MCO, DVR, or other entity, as appropriate.

- Proof of denial is *not* required for low-cost items such as batteries or other AT items *not* typically covered by schools, DVR, insurance, Medicare, or Medicaid.

To determine availability of other funding options, the guardian or service coordinator should contact:

- the medical insurance and/or MCO Care Coordinator to ask if this item is typically approved through the person's insurance plan
- other potential funding sources, as appropriate, such as vocational rehabilitation (DVR) or the school system (IDEA)

Item 6: Case manager enters their name and the date the IDT reviewed/discussed/agreed to the AT equipment being requested.

Item 7: Check each box to indicate the AT equipment being requested meets the DDSD Clinical/Service funding criteria listed. See DDW Standards section 14.1.2 for details. Include an explanation of why any criteria item is NOT checked.

Item 8: Enter diagnosis(es) and functional limitations relevant and related to the AT equipment being requested.

Item 9: Justification Statement: Enter a brief and clear description of the functional activities to be supported by this AT equipment and what adaptation or features of the requested AT items will assist the person to participate in functional/meaningful daily activities.

Item 10: Complete all table columns for each piece of AT equipment being requested. A specific catalog item number or each specific item weblink may be included in the 'Item #' column. Be sure the weblink is current when submitted.

Item 11: AT Request Total: include all items, shipping and handling, taxes, or other fees included in the table above.

Item 12: Purchasing Agent Fee: Enter the sum of the AT Item Total multiplied by 15%. For example, if the AT item total is $200.00 multiplied by 15%, enter the purchasing Agent Fee of $30.00. The maximum Purchasing Agent Fee is $75.00 [up to $112.50 with use of Appendix K funds].

Item 13: Grand Total: Enter the total of AT items being requested plus the Purchasing Agent Fee.

Item 14: If the Grand Total exceeds $500.00 [$750.00 with Appendix K], please check appropriate box and enter the source of additional funding secured to complete the purchase.

Item 15: Enter the date forwarded to Case Manager

When complete: Case Manager to submit this application form along with other required documents to the appropriate processing entity.