GENERAL ASSISTIVE TECHNOLOGY FUND (ATF) APPLICATION

			(
¹ Person's Name:		² Contact Person (individual completing this application - if		DO NOT use this form if a person receives services from:		
DOB:	Lost 4 of CCN.	different from the recipient) Name:		Medically Fragile Waiver Mi Via Waiver Supports Waiver ⁴ Non-Jackson Class Members - check all that apply: ☐ Waiting to receive DD Waiver Program support		
DOB: Last 4 of SSN:		Phone:				
		E-mail:		1	receives no Waiver Service	• •
Address:		³ ☐ Contact Person will purch Delivery information for fund	ase & deliver items approved.	⁵ <u>Jackson Class Members only – check all that apply:</u> ☐ Receives DD Waiver funding		
City/State/Zip:		Mailing Address:		☐ IDT/Therapists have discussed/prioritized AT funding needs Case Manager Name: Case Manager Contact information:		
Home phone (if items are being sent directly to recipient):		City/State/Zip:		⁶ Other funding considerations: ☐ DVR, Insurance/MCO coverage, warranty replacement, etc. is not available. Attach proof of denial, as appropriate.		
Background	d Information and Plan for the Use of Request	ed AT (attach additional page	for explanation, if needed):	•		
	diagnosis(es) and functional limitations related to					
	ion Statement: What functional activities will be s	upported by this AT equipment a	and what adaptation or features	of the requested	d AT items will assist the p	erson to participate
in function	al/meaningful daily activities?					
Please incli	ude ALL information requested in the table be	low!				
	veblink for each specific item in table below.		PDF or photocopy of item/cat	alog page with	item number must be o	attached!
Quantity	Item specific weblink Item name, item number				Price each	Total per item
, ,	·	,	'			
					subtotal	
					S/H (if applicable)	
Amount requested not to exceed \$250 per individual per fiscal year						
If the request exceeds \$250, identify the source of additional funding secured to complete the purchase:					taxes	
					Total	
¹⁰ Date this	application was forwarded to CSB and Case Mana	ger (if applicable):				
	nd any remaining monies must be forwarded to the		vs of nurchasel Contact Clinical	Services directly	for current fund adjustme	ent nrocess
Neceipts ui	ia any remaining mones must be joi warded to the	e state riscar Agent within 30 da	ys of parenase: contact chinear	services uncerry	jor carrent jana aajastine	int process.
CSB Revi	ewer Section Only Total Amount Appr	Date request sent to State Fiscal Agent:				
Items De	nied (if any):	Comments:				
Signature	• • • • • • • • • • • • • • • • • • • •	1				
AAC	ADL COMP ECU	LSR MOB	POS SWC	OP SWT	TCH OTHER:	

Mail: DDSD- Clinical Services Bureau, Attn. ATF Coordinator, 5301 Central Ave, Suite 1700, Albuquerque, NM 87108 or Fax: (505) 841-2987 or SCOMM to Felicia Vidro NM DOH/DDSD Clinical Services Bureau

Revised 8/5/21

GENERAL ASSISTIVE TECHNOLOGY FUND (ATF)

Application Instructions

USE THIS APPLICATION FORM FOR: Jackson Class Members (JCM) on DD Waiver <u>OR</u> persons with IDD that do not receive funding through ANY waiver & reside in NM.

<u>Item 1:</u> Enter the person's name, DOB, Last 4 of Social Security Number, and address. Include home phone number if the requested items will be sent directly to the recipient.

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

<u>Item 3:</u> Check box if funds being requested will be sent to the contact person (rather than the recipient's home address). If the box is checked: enter the contact person's *mailing address* that is safe for receiving the check.

<u>Item 4:</u> Non Jackson Class Members – check all boxes that apply

Item 5: Jackson Class Members – check all boxes that apply

<u>Item 6:</u> Other Funding Considerations:

It is required that families or IDT members discuss and prioritize AT funding needs <u>and</u> consider 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 <u>not</u> required for low-cost items such as batteries or other AT items <u>not</u> 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 7: Enter diagnosis(es) and functional limitations relevant and related to the AT equipment being requested.

<u>Item 8:</u> 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.

<u>Item 9:</u> Complete all table columns for each piece of AT equipment being requested. A specific catalog item number or each specific item weblink must be included in the 'Item' column. Be sure the weblink is current when submitted.

* If the Grand Total exceeds \$250.00, please include the **source of additional funding** secured to complete the purchase.

<u>Item 10:</u> Enter date the completed AT Fund Application was sent to Clinical Services Bureau (CSB) [and Case Manager if applicable]. Send by SCOMM, fax, mail, or other secure method only please.

When complete: Submit this application form along with other required documents to the Clinical Services Bureau (CSB) [and Case Manager if applicable].

Questions: Felicia Vidro, Therapy Services Coordinator 505-841-5878