

DD WAIVER ASSISTIVE TECHNOLOGY FUND (ATF) APPLICATION

Please include ALL information requested

Please read pgs.
3-4 before
completing form.

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

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

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

¹ Shipping address:	² Contact Person (individual completing this application - if different from the recipient) Name: Phone: E-mail:	³ DO NOT use this form for: Medically Fragile Waiver Mi Via Waiver
City/State/Zip:	⁵ ☐ Delivery information for funds. Check box and complete ONLY IF Contact Person will purchase & deliver items approved (instead of Purchasing Agent). Cannot be guardian.	⁶ Funding Considerations/IDT Responsibilities ☐ IDT met to discuss the need/justification of items to be purchased with AT Funds & documented this in the ISP. Date: _____
Phone (contact for delivery questions):	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.
⁴ Case Manager Name:	City/State/Zip:	

Details / Plan for the use of requested AT [to be completed by the person filling out the form]:

See instructions and examples on p. 3-4.

⁷ Items support progress toward these ISP Outcomes (list any Outcomes that directly relate to items being requested):

⁸ Items increase the person's safety during participation of functional activity at home and/or in the community

☐ Yes ☐ No

⁹ **AT items will increase functional participation in**
(check all that apply)

- ☐ Employment
- ☐ Community Activities
- ☐ Activities of Daily Living
- ☐ Personal Interactions
- ☐ Leisure Activities

¹⁰ **Items are low-tech and will support physical, or communicative participation in** (check all that apply)

- ☐ Functional Activities at Home or in the Community
- ☐ Development of Augmentative Communication
- ☐ Environmental Access
- ☐ Mobility Systems

Complete one row for each AT item requested on next page (attach additional page for explanation, if needed):

¹¹ AT item requested	¹² State how the requested AT item(s) support the person's participation in any areas checked above (list diagnoses or conditions and describe barriers/challenges due to their disability or diagnoses, & how the AT item(s) addresses the need):

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

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

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

¹³ Include direct 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 * please enter quantity and price each - total will auto calculate

Quantity	Item specific weblink	Item name, item number, and descriptors	Price each	Total per item
				\$ 0.00
				\$ 0.00
				\$ 0.00
subtotal				\$ 0.00
S/H (if applicable)				
taxes				
Total				\$ 0.00

Quantity	Item specific weblink	Item name, item number, and descriptors	Price each	Total per item
				\$ 0.00
				\$ 0.00
				\$ 0.00
Subtotal				\$ 0.00
S/H (if applicable)				
Taxes				
Total				\$ 0.00
Attach additional pages if needed.				Total from any additional pages

¹⁴	AT Item Total - Sum of all items above	\$ 0.00
¹⁵	☒ 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	\$ 0.00
	OR	
	☐ AT Provider Agency/Vendor is the Direct Provider of the AT items being requested	N/A
¹⁶	AT Fund Request Grand Total **	\$ 0.00

¹⁷ ** If the AT Fund Request Grand Total exceeds \$500.00, indicate the source of additional funds being used to complete purchase
¹⁸ Date this application forwarded to Case Manager:
If Contact Person received funds and purchased items instead of the Purchasing Agent, then 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.

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 ASSISTIVE TECHNOLOGY FUND (ATF) APPLICATION

Please include ALL information requested

Please complete fillable form in your web browser and then download to desktop. Use Chrome, Firefox, or Edge. If you download the blank PDF to your computer, text formatting and auto-calculate may not work.

USE THIS APPLICATION FORM FOR: any person receiving **DD Waiver** services.

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. **ONLY** items approved may be purchased. If there are ANY changes, a revision must be submitted.

Item 1: Enter the shipping address - the home or business address where items should be delivered. Include a contact phone number for any delivery questions.

Item 2: Enter the name, phone, and email for the Contact Person completing the application (an IDT member).

Item 3: Do not use this form for individuals who receive services through the Medically Fragile Waiver or Mi Via Waiver. Please use alternate waiver-specific forms.

Item 4: Enter Case Manager name.

Item 5: **Check this box ONLY IF** the funds being requested are to be sent to the **Contact Person who will purchase & deliver items approved** (rather than the Purchasing Agent shipping the items directly to the person'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 sent directly to a guardian.

Item 6: IDT members are required to discuss and prioritize AT funding needs before submitting this application.

IDT members are required to review and agree that all items being requested align with NMAC guidance for ATF purchases. Check the box to confirm these processes have been followed. Include the date of the IDT meeting.

IDT members are required to 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)

Note: At least one item in the 'Details/Plan for use of requested AT' section (items 7-10) must be answered 'Yes' to request AT Funds.

Item 7: If requested item(s) will support progress toward any ISP Outcomes, list those Outcomes here.

Item 8: If requested item(s) will increase the person's safety during participation of functional activity at home and/or in the community, check the 'Yes' box. If not, check the 'No' box.

Item 9: Check boxes to indicate all areas the requested AT items will support.

Item 10: Check boxes to indicate if the requested items are low-tech and will support the person's physical or communicative participation in that area.

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Item 11: Enter a brief description of each AT item requested. Please group and list similar items such as walker/bag, ipad/case, adapted switch/controller, or mealtime equipment on one line.

Item 12: State how the requested AT item(s) support the person's participation in any areas checked in the 'Details/Plan for use of requested AT' section above. This should be brief and clearly describe barriers/challenges the person has due to their disability or diagnoses, and how the item(s) address the need.

Examples:

<i>Walker skis</i>	<i>Dan has a shuffling gait due to his CP diagnosis. The smooth skis will help Dan move with less effort on carpet and outdoors. The walker will be less likely to tip over when he turns. He will need less staff assist.</i>
<i>Nosey cup, adapted spoon</i>	<i>Due to CP and decreased fine motor control, Mary struggles to safely bring food and drink to her own mouth. The nosey cup and adapted spoon support increased independence and safety with self-feeding.</i>
<i>Toilet frame</i>	<i>Jesus has Down Syndrome with poor muscle tone, decreased balance, and impulsivity. The safety frame will allow him to be safer when alone in bathroom without the need for staff present.</i>
<i>VOCA</i>	<i>Jenny has a TBI and struggles to communicate verbally. The VOCA will allow her to create custom messages to be used while working on her ISP relationships outcome at the community center.</i>
<i>Multi-headed toothbrush</i>	<i>John is dependent for ADLs including oral care. Toothbrush will support his functional participation when being assisted by staff during oral care as needed for health and safety.</i>

Item 13: Complete all table columns for each piece of AT equipment being requested. A specific catalog item number or a weblink for each specific item must be included in the 'Item #' column. Be sure the weblink is current when submitted.

Item 14: AT Request Total: include all items, shipping and handling, taxes, or other fees included in the table above.

Item 15: 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.

Item 16: Grand Total: Enter the total of AT items being requested plus the Purchasing Agent Fee.

Item 17: If the Grand Total exceeds \$500.00, please enter the source of additional funding secured to complete the purchase.

Item 18: Enter the date this application was forwarded to Case Manager.

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

ATF Purchasing Agent (PA) Section Only: This section is to be used by the Assistive Technology Purchasing Agent. The person completing the form should not enter any information here.