

STATE GENERAL ASSISTIVE TECHNOLOGY FUND (ATF) APPLICATION

¹ Person's Name:		² Contact Person (person completing this application - if different from the recipient) Name: Phone: E-mail:		DO NOT use this form if a person receives services from: Medically Fragile Waiver Mi Via Waiver Supports Waiver	
DOB:					
Last 4 of SSN:					
Address:		³ ☐ Check box if Contact Person will purchase & deliver items approved. Delivery information for funds.		⁴ <u>Other funding considerations:</u> ☐ DVR, Insurance/MCO coverage, warranty replacement, etc. is not available. <i>Attach proof of denial, as appropriate.</i>	
City/State/Zip:		Mailing Address:			
Home phone (if items are being sent directly to recipient):		City/State/Zip:			

Background Information and Plan for the Use of Requested AT (attach additional page for explanation, if needed):

⁵ AT item(s) being requested will assist the person with: ☐ communication ☐ physical function which supports interaction with others ☐ mobility ☐ environmental access
☐ activities of daily living ☐ recreation ☐ work ☐ volunteerism ☐ community integration

⁶ Justification Statement: Describe how the requested AT items will assist the person to actively participate in functional daily routines and meaningful activities.

Please include ALL information requested in the table below!

⁷ 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
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:			subtotal	
			S/H (if applicable)	
			taxes	
			Total	

⁸Date this application was forwarded to CSB:

Receipts and any remaining funds must be forwarded to the State Fiscal Agent within 30 days of purchase! Contact Clinical Services directly for current fund adjustment process.

CSB Reviewer Section Only		Total Amount Approved:	Date request sent to State Fiscal Agent:
Items Denied (if any):			Comments:
Signature:	Date:		

STATE GENERAL ASSISTIVE TECHNOLOGY FUND (ATF)

Application Instructions

USE THIS APPLICATION FORM FOR: People with Intellectual and Developmental Disabilities that do not receive funding through ANY waiver and reside in NM.

Item 1: Enter the person's name, DOB, Last 4 of Social Security Number, and address (for shipping). Include 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.

Item 3: Check box if funds being requested will be sent to the contact person to purchase the item(s) (rather than the items being delivered 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.

Item 4: Other Funding Considerations:

It is required that families discuss and prioritize AT funding needs and 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 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 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 5: Check all boxes relevant and related to the AT item(s) being requested.

Item 6: Justification Statement: Enter a brief and clear description of how the requested AT items will assist the person to actively participate in functional daily routines and meaningful activities.

Item 7: 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.

Item 8: Enter date the completed AT Fund Application was sent to Clinical Services Bureau (CSB).

When complete: Submit this application form to the Clinical Services Bureau (CSB). Send by SCOMM, mail, or other secure method only please.

Questions: Moses Martinez Therapy Services Coordinator at 505-527-3611