

GENERAL ASSISTIVE TECHNOLOGY FUND (ATF)

Application Instructions

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

Item 1: 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.

Item 3: 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.

Item 4: Non Jackson Class Members – check all boxes that apply

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

Item 6: Other Funding Considerations:

It is required that families or IDT members 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 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.

Item 8: 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 9: 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 10: 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