**Pursuant to Chapter 44 of the Department of Health’s Medicaid Rules**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Participant Name:** |   | **Age:** |   | **Submission Date:** |   |

**Diagnosis and Medical Condition:**

**Equipment Description:**

**The following equipment will be denied:**

\*\**Even if prescribed by a licensed health care professional. (See Chapter 44, Section 6 for complete rule.) If a participant uses waiver funding to purchase equipment that doesn’t meet definition, the specialized equipment provider will be responsible for refunding the state for the expenditure.*

* Items available under Medicaid State Plan or Early Periodic Screening, Diagnosis, and Treatment (EPSDT)
* Educational or therapy items that are an extension of services provided by Department of Education
* Items of general use that are not specific to a disability, or that would normally be available to any child or adult
* Pools, spas, hot tubs or modification to install pools, spas, or hot tubs
* Computers and computer equipment, including the CPU, hard drives, and printers
* Items that are not proven interventions through either professional peer reviews or evidence based studies
* Communication items such as a telephone, pagers, pre-paid minute cards, or monthly services

**Specialized equipment shall be functionally necessary and meet at least two (2) of the following criteria:**

|  |  |  |
| --- | --- | --- |
| 1. Be necessary to increase ability to perform activities of daily living, or to perceive, control, or communicate with the environment in which the person lives | [ ]  Yes  | [ ]  No  |
| 2. Be necessary to enable the participant to function with greater independence, and without which the person would require institutionalization. | [ ]  Yes  | [ ]  No  |
| 3. Be necessary to ensure the person’s health, welfare, and safety | [ ]  Yes  | [ ]  No  |

**Individualized plan of care shall reflect:**

|  |  |  |
| --- | --- | --- |
| * Need for equipment
 | [ ]  Yes  | [ ]  No  |
| * How equipment addresses accessibility, health, and/or safety
 | [ ]  Yes  | [ ]  No  |
| * How equipment allows participant to function with greater independence
 | [ ]  Yes  | [ ]  No  |
| * Information on how often the equipment is used, and where it is used
 | [ ]  Yes  | [ ]  No  |

**Signed, dated recommendation from therapist or professional with expertise in the area of need must be presented on letterhead and include:**

**(Recommendations must be per piece or type of equipment)**

|  |  |  |
| --- | --- | --- |
| * Description of the functional need for the specialized equipment
 | [ ]  Yes  | [ ]  No  |
| * How equipment will contribute to a participant’s ability to remain in, or return to, their home and out of an institution
 | [ ]  Yes  | [ ]  No  |
| * How equipment will increase the participant’s independence and decrease need for other services
 | [ ]  Yes  | [ ]  No  |
| * How equipment addresses accessibility, health, or safety needs
 | [ ]  Yes  | [ ]  No  |
| * Documentation that participant has the capacity to use the equipment
 | [ ]  Yes  | [ ]  No  |

**Additional Documentation:**

|  |  |  |
| --- | --- | --- |
| * Documentation that waiver is payer of last resort
 | [ ]  Yes  | [ ]  No  |
| * Documentation that equipment is not available through Medicaid, EPSDT, or insurance
 | [ ]  Yes  | [ ]  No  |
| * Description of how equipment shall be delivered and who will train the participant and providers on the equipment
 | [ ]  Yes  | [ ]  No  |
| * Documentation of two (2) quotes for the purchase of the equipment, including a maximum mark up on the equipment of 20%
 | [ ]  Yes  | [ ]  No  |
| * Quote may include a detailed description of the needs and costs for training or expert assembly in addition to the 20% mark up
 | [ ]  Yes  | [ ]  No  |

|  |  |  |
| --- | --- | --- |
| * If the participant has an Individualized Education Plan (IEP) or Individual Family Service Plan (IFSP), a copy of that document, along with documentation as to why the equipment is not sent home with the participant or reason why the equipment is necessary at home and not at school.
 | [ ]  Yes  | [ ]  No  |

***\*\* The Division may request proof that a less expensive, comparable alternative to requested equipment or supplies are not available or practical. If a more cost-effective alternative is determined to be available, the Division shall deny the original request or specify that the amount of the less costly equipment or supplies are approved.***

Additional Information:

Printed name of case manager:

Signature:

Date: