

CCW Assistive Technology Request Worksheet



Participant Name:

Submission Date:

97755 Assistive Technology Service T2028 Assistive Technology Equipment

Assistive Technology request shall be functionally necessary and shall:

<ul style="list-style-type: none"> Improve or maintain the participant’s level of independence 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<ul style="list-style-type: none"> Enhance the participant’s ability to perform activities of daily living 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<ul style="list-style-type: none"> Assist the participant to access needed supports and services within the community 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<ul style="list-style-type: none"> Be necessary to ensure the person’s health, welfare, and safety 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<ul style="list-style-type: none"> Identified in the participant’s person-centered service plan 	<input type="checkbox"/> Yes <input type="checkbox"/> No

Description of the concern or need that necessitates the equipment:

Explanation of how addressing the concern or need will: 1) Contribute to the participant’s ability to remain independent or increase independence; 2) Address the participant’s accessibility concerns; and 3) Address health and safety needs of the participant.

Attach an estimate/quote from an Assistive Technology Provider that includes:

<ul style="list-style-type: none"> Detailed description of the assistive technology. 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<ul style="list-style-type: none"> An itemized estimate of the item, equipment, or product system. 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<ul style="list-style-type: none"> Name, address, and telephone number of the provider 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<ul style="list-style-type: none"> Signature of the provider 	<input type="checkbox"/> Yes <input type="checkbox"/> No

Attach additional documentation for requests over \$1,000:

<p>1. Signed evaluation by a licensed occupational therapist; a speech, hearing, or language therapist; a physical therapist; a certified assistive technology professional; or other professional meeting all applicable WDH standards, including regulations, policies, and procedures relating to provider qualifications.</p>		<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>If no, proceed to 2.</i></p>
<p>2. Evidence of the Division waiving the professional evaluation. Functional assessment must be completed by the case manager as part of the person-centered planning process and be included in the person-centered service plan.</p> <p><i>Evidence includes email approval and a note in the CCMS from the assigned County Benefits and Eligibility Specialist.</i></p>		<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> N/A</p>
<p>List of previous assistive technology purchased through the waiver</p>		<p><input type="checkbox"/> N/A</p>
Date Approved	Total Amount	Description of the Assistive Technology

Additional Information:

Third Party Liability

<ul style="list-style-type: none">● Team has confirmed that no other funding source is available as the Waiver is the payor of last resort.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<ul style="list-style-type: none">● Third Party Liability Form is complete	<input type="checkbox"/> Yes <input type="checkbox"/> No

*** By federal law (42 CFR §433 Subpart D, §433.138, and 433.139), third parties that are responsible for payment of services must be identified. The CCW is considered the payer of last resort. The case manager attests that no other insurer or program, such as the Department of Workforce Services or Division of Vocational Rehabilitation, Department of Education, Medicaid State Plan, Medicare, Division of Aging, state and federal grants, private insurers, or other available programs, is responsible for the cost or part of the cost of the services outlined on this form.*

Participant signature or LAR: _____

Printed name of case manager: _____

Case manager signature: _____

Date: _____