NYC EARLY INTERVENTION PROGRAM
ASSISTIVE TECHNOLOGY SPECIFICATION FORM

SERVICE COORDINATOR MUST CHECK FOR COMPLETE PACKET.
COMPLETE ALL INFORMATION REQUESTED.

TO: **Assistive Technology Unit**

FROM:

SC Name: ____

SC Provider Agency: ______________________________________

Contact #: ______________________ Fax #: ______________________

RE:

Child's Name: ____

EI #: ______________________ D.O.B: ______________________

Attached is a request for Assistive Technology for the above-named child. A check mark in the appropriate box indicates that the specified item is included with this request.

- ❑ Complete and accurate justification of the AT need with signatures of the ordering therapist, doctor or audiologist, and the parent.
- ❑ Child insurance information
- ❑ MD prescription
- ❑ Complete and current IFSP-Packet
- ❑ Vendor information

  and/or
- ❑ Catalogue information

Note: The request packet must be legible, complete, and mailed to the address listed below.

Early Intervention Program – Assistive Technology Unit
93 Worth Street, Room 915
New York, NY 10013

I have verified that this request is complete and legible.

______________________________ ______________________

Signature of Service Coordinator **Date Signed**

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Child's Name: ______________________ (Last) ______________________ (First) EI ID #: ______________________

D.O.B.: ____/____/____ Borough: ______________________

Parent's Name: ______________________ (Last) ______________________ (First) Phone #: (____) ______________________

Address: ______________________

Child's Diagnosis: ______________________

THERAPIST RECOMMENDING THE DEVICE:

Name: ______________________ Discipline: ______________________

Agency Affiliation of the recommending therapist:

Agency Name: ______________________ Contact #: ______________________

Ongoing Service Coordinator: ______________________ ID #: ______________________

Phone #: (____) ______________________ Fax #: (____) ______________________

SC Agency: ______________________

INSURANCE INFORMATION:

Medicaid Eligible: ☐ Yes ☐ No Private Insurance: ☐ Yes ☐ No

Child's Medicaid or CIN #: ____/____/____/____/____/____/____/____/____

Child's Private Insurance Name: ______________________

Policy Holder Name: ______________________ Relationship to Child: ______________________

Policy #: ______________________ Group Name and #: ______________________

Device being requested: ______________________

Please indicate if assistance is needed from the AT unit in finding a vendor: ☐ Yes ☐ No
Please submit the specifications and cost of all items on either vendor or catalogue letterhead.
Include the following: name of item(s); list of accessory(ies); itemized cost of each item; shipping/handling charges; total charges; a picture of the device when available.

Is the device available for loan through TRAID? ☐ Yes ☐ No
If yes, will the family be borrowing the device while this order is being processed? ☐ Yes ☐ No

Describe other A.T. equipment/devices that are presently used by the child and are found within the home environment:

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Child's Name: ______________________________ **EI ID #:** ____________________
(Last) (First)

DESIRED OUTCOMES – Identify the functional outcomes expected to be attained by the child as a result of the use of this device/item during this IFSP period. Describe how the device/item will be used to accomplish these outcomes.

PLAN FOR USE OF THIS DEVICE – How will the device be used? Frequency and duration? By whom? In what setting (i.e. home, center)? If used by more than one therapist, specify goals foe each discipline. Specify if parent will be using the device and any precautions or safety factors they should be made aware of. Indicate other AT equipment in the home. Does this item replace/supplement other equipment?

DURATION – What is the anticipated period of time (months/years) device will be used by the child?

I have discussed with the family and other therapists (if applicable), the possible use(s) of this equipment as an integral part of the child's Early Intervention services as stated on the IFSP.

Therapist's Signature (name/discipline): ______________________________ Date: ____/____/____

Therapist's Name: PRINT ______________________________

Parent/Guardian's Signature: ______________________________ Date: ____/____/____

TO THE RECOMMENDING THERAPIST :

In an effort to expedite the EIP-Assistive Technology Specification process, please review your papers to be sure that the following considerations have been addressed: *

REQUESTED ITEM/DEVICE IS:

- ❑ to be used to increase, maintain or improve self-help skills and functional abilities related to daily living activities and family routines.
- ❑ to be used within the home setting by all caregivers, not just by the EI interventionists.
- ❑ functionally appropriate for use within the child's household considering the item's bulk or size, weight and ease of family use.
- ❑ to be used to implement outcomes set for the child and family within the current IFSP time period.
- ❑ recommended in collaboration with the child's EI interventionist(s) team.
- ❑ not a duplication of equipment which was purchased for the child's use either by the NYC EIP or any other source. If this item is to replace a like item, reasons for replacement must be clearly documented.
- ❑ ordered through a vendor (or catalog order for small items) with whom the recommended therapist has had good working experiences.
- ❑ clearly defined and its uses fully clarified with the child's caregivers.

DOCUMENTATION SUBMITTED CONTAINS:

- ❑ clear documentation as to the need for the device.
- ❑ specific rationale for choosing the particular type of item being requested.

*** This page is <u>not</u> required for hearing aid device orders and/or orthotic orders.**

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TO BE COMPLETED BY THE RECOMMENDING THERAPIST AND SUBMITTED TO THE ASSISTIVE TECHNOLOGY UNIT BY THE SERVICE COORDINATOR UPON RECEIPT BY THE CHILD/FAMILY OF THE ASSISTIVE TECHNOLOGY DEVICE ORDERED:

NOTIFICATION OF RECEIPT OF AT DEVICE:

Child's Name: ____________________ (Last) ____________________ (First) EI ID #: ____________________

Therapist's Name: ____________________ (Last) ____________________ (First) Discipline: ____________________

Vendor who fulfilled order: ____________________

Date of receipt of item: ______/______/______

Item received in good condition: ☐ Yes ☐ No

If no, indicate problem and resolution of the problem:

ATTACHMENT:

Attach a copy of the signed merchandise receipt/packing slip where appropriate. If this is not appropriate, please indicate reason:

SIGNATURES:

Therapist: ____________________

Parent/Caregiver: ____________________