NEW YORK STATE OF OPPORTUNITY. | Office for People With Developmental Disabilities

Region 2

INITIAL REQUEST FOR AN ADAPTIVE DEVICE,
ENVIRONMENTAL MODIFICATION AND/OR VEHICLE MODIFICATION

I. APPLICANT INFORMATION

Name: _____ DOB: _____ County: _____

Address: _____ TABS #: _____ Last 4 of SS #: _____

_____ MEDICAID #: _____

Telephone #: _____ Email: _____

Current Living Situation (with family, alone, certified FC, other): _____

Contact Person: _____ Relationship: _____

Address (if different from applicant): _____

_____

Telephone #: _____ Email: _____

II. CARE MANAGER INFORMATION

Name of Care Manager Completing Form: _____

Agency: _____ Telephone #: _____

Address: _____ Email: _____

_____

III. Care Manager Supervisor Email: _____

IV. Individual's Enrollment Date for the HCBS Waiver: _____

V. Date of Eligibility (attach letter, if applicable): Formal ☐ SGE ☐ Provisional ☐

VI. Does the Individual receive Medicare? Yes ☐ No ☐ Medicare number: _____

Does the Individual have private health insurance? Yes ☐ No ☐

Policy provider and number: _____

VII. Additional information: _____

_____

Has the person previously received an environmental modification, vehicle modification or adaptive device? Yes ☐ No ☐

If yes, please describe, including approximate dates of service:

_____

_____

Please provide a brief description of needs and the home modification/equipment needed (attach each person's Life Plan):

_____

_____

_____

Clinical Input and Physician's Letter of Medical Necessity are required for all Assistive Technology, Environmental Modifications & Vehicle Modifications projects. Please attach Physician's Letter and OT/PT/BIS/SLP clinical evaluation substantiating the request to the application.

Please describe all attempts that were made to secure funding for this need elsewhere (i.e., community resources such as TRAID, local municipalities, loan closets, county resources and charitable organizations).

For all Durable Medical Equipment (DME) please ensure that Private Insurance, Medicaid and Medicare are accessed before this application is submitted to the AT Program for funding.

This question cannot be left blank, or application will be returned:

_____

_____

_____

By signing this form, The Care Manager asserts that other sources of funding for this Assistive Technology, Environmental Modification, Vehicle Modification or Adaptive Device are not available.

_____ Date: _____

(Care Manager's signature)

_____

(Print name)

As with any new service provider, the Care Manager should work with the individual/family to facilitate choice of provider in accordance with the family's preferences and needs. Questions to ask potential providers may include the agency's experience with a certain type of project or anticipated time frame of scope development/bid solicitation. Best practice would be to contact the preferred agency in advance of submitting this request to ensure that the agency is able to accept the project in a timely manner.

OPWDD Region 2

INITIAL REQUEST FOR AN ENVIRONMENTAL MODIFICATION AND/OR ADAPTIVE DEVICE INSTRUCTIONS

For all new requests for Assistive Technologies, Environmental Modifications and Vehicle Modifications (AT/EM/VM) funded under the Home and Community Based Waiver. The attached application form will need to be completed and forwarded to the following mailbox:

Email: opwdd.sm.region2.emods@opwdd.ny.gov

It is advisable to follow up with the AT Coordinator approximately one week after submission, if you have not heard anything on the status by then, to confirm receipt.

I. Applicant Information

Demographic information: Enter the individual's name, birth date, county, address, TABS number, last 4 of SS#, Medicaid CIN, telephone number, and current living situation. Where more than one person in the home requires assistance, please complete a separate request form for each individual. If the current address differs from the address where an Environmental Modification is being requested, attach an explanation to this form.

Contact person for questions and/or access to the site: Provide contact information for the person who will grant access to the site or arrange visits with the individual. Only provide an e-mail address when this is the preferred mode of communication.

II. Care Manager Information

Enter the Care Manager name and contact information in this section. Email will be the primary means of communication.

III. Care Manager Supervisor Email

IV. Waiver information

Indicate Waiver enrollment date for the individual.

V. Eligibility information

Indicate whether individual has formal, system-generated, or provisional eligibility and attach any relevant documentation.

VI. Insurance information

Indicate whether the individual has health insurance other than Medicaid and provide policy numbers.

VII. Additional information

Past projects: Indicate any other home modifications or adaptive devices received through the HCBS Waiver.

Description of Need: Briefly describe the reason for this request. This should be explained in greater detail in the individual's Life Plan and it should be attached to the application. The following is required:

- Physical and developmental conditions and limitations,
- Assessment of home environment, including obstacles that limit independence, and
- Environmental Modifications and Assistive Technology items that will reduce obstacles

Clinical Input: Clinical must be attached to the application at the time of submission.

Physician's Note: A Letter of Justification signed by the physician must be submitted with each application.

Funding Sources: The Assistive Technology (AT) Program requires a list of community resources that were sought to fund each request, DME, E-MOD, and V-MOD. AT also required insurance denials from Medicaid, Medicare and/or Private Insurance for items that may be funded by insurance, such as Durable Medical Equipment (DME). If the community resources are not listed and if insurance denials for DME are not included with this application it cannot be considered for HSBC Waiver funding and will be returned.

For the purchase of many Adaptive Devices, it will be necessary for the individual, family member, Care Manager, or clinician to contact any insurance carriers to seek coverage. A written denial from a third-party insurer, including Medicaid, must be attached to this request form, unless the recommending clinician verifies that other funding sources have been investigated and have been found unavailable. When applicable, a copy of this finding must be attached to the clinical evaluation in lieu of a denial.