ASSISTIVE TECHNOLOGY (AT) DESCRIPTION AND COST PROJECTION

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
TRAUMATIC BRAIN INJURY (TBI)

Applicant/Participant           CIN

1. Describe the Assistive Technology being requested.

2. Explain how the Assistive Technology will help contribute toward the applicant/participant's health and welfare.

3. Attach all assessments and bids. Identify the selected bid.
   
   NOTE: If this is a rental property, a signed authorization from the landlord must be attached.

Applicant/Participant Signature           Date

Legal Guardian /Representative (as applicable)   Signature           Date

Assistive Technology Provider: ____________________________ Provider ID#: ____________

Contact Person: __________________________________________

Signature: ____________________________

Service Coordinator: ____________________________

Signature: ____________________________ Date: ____________

Regional Resource Development Specialist (RRDS): ____________________________

Signature: ____________________________ Date: ____________

□ Approved     □ Denied

Reason for denial: __________________________________________

DOH Waiver Management Staff (if over $15,000): ____________________________

Signature: ____________________________ Date: ____________