UF DEPT OF PEDIATRICS NORTH CENTRAL EARLY STEPS ASSISTIVE TECHNOLOGY REQUEST FORM

Please print clearly, complete entire request form and include required attachments.

Child’s Name: ___________________________  DOB: ___________________________

Medicaid Eligible? (Circle one)  NO  □

If YES, enter 9-digit Medicaid # here: ___________________________

If TPIN, please attach insurance denial:

Assistive Technology Assessment Date and Established IFSP Outcome with use of Assistive Technology Tool Recommended:

Where is the device used? — (List the specific locations where the device will be used (home, child care, etc.)): ___________________________

When is the device to be used? — (Identify the daily routine that device will be used in to support the child’s independence): ___________________________

Loaner or natural supports were provided and used by the family/caregiver, if available?  Yes □  No □

Comments:

IFSP Team members:

Item(s) Recommended: (Please attach: Copy of Catalog Description and Price)

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<tr>
<th>Item</th>
<th>Model</th>
<th>Manufacturer</th>
<th>Vendor</th>
<th>Medicaid DME Code</th>
<th>Price at Medicaid Rate</th>
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The Following Documentation must be included with this request:

_____ IFSP sections: Page E, F and G
_____ Copy of Dated & Signed credentialed evaluator letter of necessity supporting request
_____ Copy of Dated & Signed Physician’s Prescription
_____ Copy of vendor quote including options/accessories breakdown
_____ Picture & pricing of item(s)