NIAGARA COUNTY EARLY INTERVENTION PROGRAM
ASSISTIVE TECHNOLOGY MEDICAL NECESSITY JUSTIFICATION

Therapist: Please complete each of the following questions for each Assistive Technology Device (ATD) being requested, as detailed in the attached instructions. In an effort to streamline Early Intervention authorization as well as facilitate third-party commercial insurance and Medicaid approval, your answers should reflect where and how the ATD will be used by this child to support both 1) medical needs and 2) Early Intervention Individualized Family Service Plan (IFSP) functional outcomes.

Recommending Therapist must ensure a complete, current and legible AT packet (this *Assistive Technology Medical Necessity Justification* form, the Recommending Therapist's current progress note, and the prescription for the exact device and required accessories) is submitted to the Service Coordinator for submission to the local Early Intervention Program (EIP).

Service Coordinator: Transmit the complete AT packet provided to you from the Recommending Therapist to the local EIP through a secure process, preferably HCS.

Child's Name:	
Child's Date of Birth:	**NYEIS ID:**
Current Medical Equipment in Use:	
Current Assistive Technology Devices in Use:	
Recommending Therapist's Name:	**Discipline:**
Phone:	**Email:**
If completed by a Certified Occupational Therapy Assistant or Physical Therapy Assistant, name of the supervising OT or PT:	
EI Provider Agency (As applicable):	**AT Coordinator (As applicable):**
Service Coordinator's Name:	
Phone:	**Email:**
Location of Service Provision (select at least one): ☐ **Home** ☐ **EI Facility Based** ☐ **Community/Day Care** ☐ **Other:**	
I. TRAID Center: Recommending Therapists must contact the **TRAID Center** (preferably email): [*Specific TRAID Center info*] to ask about device availability. They must document the outcome of this effort in order for any device to be authorized by the EIP.	
Date TRAID contacted:	
Outcome: ☐TRAID will provide a loan for ____ months with an anticipated delivery date of: _____ ☐TRAID is unable to provide a loaner ATD in this category ☐No TRAID contact required for amplification or custom devices ☐ No response from TRAID at the time of request submission Document attempts:	

II. ATD Vendor, Recommending Therapist, Family, and Child Collaboration	
Date of ATD Vendor Collaboration:	**ATD Category:**
ATD Model:	
ATD Manufacturer:	
Location for Use:	
Does this child already have an ATD and is the requested device compatible?	
Identify the complete list of required device accessories, customizations and/or additions that apply to this exact ATD:	
II. Relevant Medical and Developmental Justification	
1. Describe in detail the child's medical conditions and history that are relevant to the need for this ATD. Detail how each condition is manifested in this child and how it impacts their functional abilities.	
2. Describe how this ATD will address the child's medical needs as well as their functional abilities.	
3. What is the anticipated time frame in which this child will benefit from this ATD to improve functional abilities and address medical condition(s)?	
4. What other therapy interventions/methods have been tried and what was the outcome?	

5. What no tech or lower tech devices have you and the family considered or used prior to this ATD request?

a. Describe the no-tech or lower-tech device considered and/or trialed. If a no-tech or lower-tech device has not been considered or trialed, provide a reason:

b. If no tech or lower tech devices were trialed, indicate the exact device(s) and describe the outcomes encountered by this child with the use of each ATD that was trialed.

6. Describe how the use of the requested ATD may impact the therapy provision and/or medical intervention(s).

7. Identify a documented IFSP outcome that supports this child's use of this device to improve functional abilities.

8. How will the requested ATD help this child meet developmental outcomes?

9. Indicate any precautions related to the child's medical/developmental condition(s) that may impact the safe use of the device.

10. List any other ATD being requested or currently used by this child. Include ATD(s) procured outside of EI or on loan. Describe HOW the ATD being requested may be used together with these other devices if applicable.

11. Describe how this device will be integrated into the child's and family's natural routines. Include training details you will provide to the family to ensure safe and integrated use.

12. Describe how you will use the device with the child. How will you determine when and how to modify the use of the ATD based on the child's progress?

13. If other EI clinicians are serving this child, how will you collaborate with them on the use of this ATD?

Recommending Therapist Signature: _____

Date: _____

Supervising OT/ PT Signature if request completed by COTA/PTA:

_____

Date: _____

Parent Consent: By signing this form, I understand that I may need to travel to the Vendor's location if this device is authorized by the Early Intervention Program. In addition, I understand that this device may be used during preschool special education (CPSE) services if this device continues to be appropriate to support my child's goals after s/he leaves the Early Intervention Program.

Parent Signature: _____

Date: _____