

# NYC Early Intervention Program Assistive Technology Medical Necessity Justification Form

**Service Providers:** The Individual Rendering Provider must complete the form below for each requested category of Assistive Technology Devices (ATD). Service providers must contact the TRAIID Center (212-677-7400 ext. 712) to determine ATD availability and document the outcome in order for the ATD category to be considered for authorization through the EIP. Submit this completed form, the physician's order/recommendation, and the most current Progress Note written by the Individual Rendering Provider who is recommending the ATD to the child's Service Coordinator within 1 week of obtaining all of these required elements. A complete submission is required in order to support Medicaid and private insurance billing. If additional pages are included, indicate which question is being answered.

**Service Coordinators:** Fax the completed ATD packet to the NYC AT Unit: 347-396-8967.

Child's Name: _____	DOB: ____/____/____
EI #: _____	Service Type: _____
Service Location: _____	
Child's Diagnosed Condition(s): _____	ICD-9 Code(s): _____
Individual Rendering Provider's Name: _____	Credentials: _____
Can the child and caregiver travel to vendor location? <input type="checkbox"/> Yes <input type="checkbox"/> No	
1. On what date did you contact the TRAIID Center Loan Closet? (required) _____ <input type="checkbox"/> TRAIID will provide a short-term loan until the requested device, if approved, is ordered and delivered to the family. <input type="checkbox"/> TRAIID will provide a long-term loan for the duration of the child's anticipated use. <ul style="list-style-type: none"> <li><input type="checkbox"/> Anticipated provision date: _____</li> <li><input type="checkbox"/> Anticipated length of loan: _____</li> </ul> <input type="checkbox"/> TRAIID was contacted - device is not available.	
2. Requested ATD category:  2a. List each accessory of the ATD category requested. Justify why each accessory is required to meet the child's current functional skills and ensures the child's safe and functional use of the ATD category:	
3. List the existing and new (if necessary) functional IFSP outcomes that the requested ATD category will address:	
4. Describe how the ATD category will help the child increase, maintain or improve his/her functional capabilities and meet his/her unique developmental needs and the IFSP functional outcomes:	
5. Indicate any precautions related to the child's medical/developmental condition(s) that may impact the safe use of the device:	

6. Describe how the ATD category will be integrated into the child's and the family's natural routines (include the settings where the device will be used, the routine activities, and the frequency with which the device will be used):

7. What lower-tech devices have you and the family discussed or used prior to this request? Explain why they are not appropriate for this child:

8. Identify any other ATD categories and/or adaptive items currently used by other Individual Rendering Providers, family, or by you, and describe how the requested ATD category may be used with them and any other requested ATD:

9. Describe how you will collaborate with the other Individual Rendering Providers serving this child and family (in the same setting or across settings) in the use of the proposed ATD category (if no other Individual Rendering Providers are serving this child, write "Not Applicable"):

10. List the parents/caregivers that require training on the device, and list the specific items that need to be addressed in that training to ensure the parents'/caregivers' safe and functional use of the ATD category:

I understand and agree that if any ATD equipment is authorized for my child, I will not use the delivered device or allow my child to use the device until my therapist has instructed me in its safe and appropriate use.

Parent/Caregiver Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Individual Rendering Provider Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

License/Certification #: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**NYC EARLY INTERVENTION PROGRAM  
ASSISTIVE TECHNOLOGY MEDICAL NECESSITY FORM INSTRUCTIONS FOR COMPLETION**

**GENERAL DIRECTIONS**

The Individual Rendering Provider is required to complete this form for each device being requested and submit it to his/her EI agency's AT Agency Coordinator for submission to the child's Service Coordinator. The Individual Rendering Provider is responsible for contacting the TRAIID (Regional Technology Related Assistance for Individuals with Disabilities) Center (212-677-7400 ext. 712) to inquire about device availability. Documentation of the outcome of this discussion is required for this device to be considered for authorization by the NYC EIP. If you attach additional pages, please indicate which question(s) you are answering. All questions are required and must be answered fully.

<b>Child's Name, EI #, DOB,</b>	Ensure that all identifying information is correct. The EI# is the child's reference number identified in NYEIS (it appears at the top of the Child Homepage in NYEIS). Information must match the information in NYEIS (do not use alternate/nicknames).
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<b>Service Type, Service Location</b>	Indicate the service type and service location.
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<b>Child's Diagnosed Conditions, ICD-9 Codes</b>	Indicate the child's diagnosed medical and/or developmental condition(s). ICD-9 codes are required to correspond to diagnosed conditions (e.g., ASD, 299.0).
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<b>Individual Rendering Provider's Name, Credentials</b>	Provide the name and credentials of the current Individual Rendering Provider that is completing this form and recommending this device (e.g., speech therapist: Speech/language Pathologist, MS, CCC/SP). If you are a certified professional, indicate "certified" and <u>do not</u> write the certification number. OTAs must include the license number of their supervisor.
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<b>Can the child and caregiver travel to vendor location?</b>	Indicate whether the child and caregiver can travel to the selected vendor. The determination should reflect the child's capacity to travel safely. For example, a child who is dependent on oxygen, resulting typically in susceptibility to illness, would benefit from a vendor and Individual Rendering Provider meeting in the child's home.
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<b>The TRAIID Center Loan Closet 212-677-7400 ext. 712</b>	TRAIID Center Loan Closets are equipped with ATD specifically for children eligible for the Early Intervention Program. Equipment from a loan closet may be provided to the child and family on either a short-term basis to determine the appropriateness of a device for the child or for the duration indicated in the child's IFSP. The availability of the device and timeframe of this loan is dependent on TRAIID's resources. All devices loaned through the TRAIID Center must be returned to the TRAIID Center in accordance with the terms of the loan.
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**Question #1: Contact with the TRAIID is a required part of all ATD requests.**

<b>1. On what date did you contact the TRAIID Center Loan Closet?</b>	Indicate the date of your call to the TRAIID Center Loan Closet. Check off one of the following outcomes and add the relevant information. The TRAIID Center Loan Closet (TCLC) has confirmed that: a. A short-term loan is available. b. A long-term loan is available. i. Provide the loaner begin date (from the TCLC to the family) ii. Provide the TCLC's timeframe (begin date to return date) for the loan of this device c. The device is unavailable for short-term or long-term loan by TCLC.
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Questions #2 to #12: Document the ATD request and justify how it is necessary to maintain or improve the functional capabilities of the child.

**2. Requested ATD category**

- Indicate the category of ATD requested for this child.
- Refer to the chart below for examples of common ATDs (Note: This list is meant to provide examples and is not exhaustive).

	<b>ATD Category</b>
DME - Independent Mobility, Positioning, DME ADL, Seating and Transport Devices	Bath System Crawler Gait Trainer/Walker Orthopedic Car Seat Pediatric Wheelchair Positioning System and Wedges Seating Stander Adaptive Stroller Adaptive Toileting and Adaptive Potty Systems
DME - Head Support	Protective Helmet Un-mounted and Mounted Head Supports
Hearing	Hearing Aid(s) and Amplification Accessories FM System and FM System Accessories
Orthoses	Orthoses (KAFO, SMO, UCBL, AFO, Orth. Shoes)

	Orthoses (WHO, elbow)
	Orthoses (Theratogs/Benik/TLSO/Hip Holders/SPIO)
Vision	Eyeglasses (incl. sunglasses/protective)

**2a. List each accessory of the ATD category requested. Justify why each accessory is required to meet the child’s current functional skills and ensures this child’s safe and functional use of the ATD category:**

- a. List each requested accessory of the selected ATD category.
- b. Justify the need for each individual accessory.
  - i. A justification is required to explain how each accessory will support this individual child’s functional abilities and skills and safe and optimal use of the device. For example, the Individual Rendering Provider may recommend a stander:
    - The Individual Rendering Provider must identify how the stander will support the child’s gross motor skills and functional abilities, and
    - Based on the identified functional capacities, the Individual Rendering Provider also determines all accessories required to meet the child’s safe and optimal use of the device

**For example, the ATD category is Seating. Based on the needs of the child, a justification for each accessory for the Seating such as a pelvic harness, a head rest, or side pads should include how it supports the child’s skills and ensures the child’s safe and optimal utilization of the ATD.**

**3. List the existing IFSP functional outcomes, as well as any new functional outcomes added since the IFSP, that the requested ATD category will address:**

- a. ATD should facilitate the attainment of the IFSP functional outcomes included in the child and family’s Individualized Family Service Plan (IFSP).
  - i. Document the current IFSP functional outcome(s) that will be addressed with the requested device category and any new functional outcomes that will be developed related to this device.
  - ii. New outcomes are required to be written in the appropriate functional outcome format, using the following **6** components of a functional outcome:

**Who:** This is usually the child but may include the parent or family.

**Will do what:** This is what the child will do (that is reasonable for the next 6 months).

**Criteria for success:** This is how everyone on the team including the parents/caregivers will know that the outcome has been met. It should be observable. It should not be described in percentages or ratios or as more or less.

**Under what condition:** This is any specific situation or adaptation (e.g., physical prompt by parent, special spoon for meal times) that is reasonable. When this is not indicated in the outcome, it is assumed to be 100% independence.

**Routine activity:** This is an event that typically occurs during the child’s day and is individualized by the family’s culture and environment.

**“So that”:** This is what the family would like to achieve or the reason why it is important.

**For example:**

| Justin | will eat an entire meal| using an adaptive spoon| during all | meal times | so that he can feed himself.  
*(who) (will do what) (under what condition) (criteria for success) (routine activity) (why it is important to the family)*

Note: For more information/training on functional outcomes, go to the NYC EIP website: <http://www.nyc.gov/html/doh/html/hcp/ei-hcp.shtml> To use the Functional Outcome Assistant Tool and Key, go to <http://www.nyc.gov/html/doh/downloads/pdf/earlyint/ei-functional-outcomes.pdf>

**4. Describe how the ATD category will help the child increase, maintain or improve the child’s functional capabilities and meet his/her unique developmental needs and the IFSP functional outcomes:**

- a. Document how the requested assistive technology category meets the child’s current and specific developmental needs, functional abilities, and family priorities.
  - i. Highlight how the requested device category will help increase, maintain, or improve the child’s functional capabilities.
  - ii. **This section should explain how the ATD device category is developmentally relevant to the child’s functional capacities and supports the achievement of the IFSP functional outcomes and family priorities.**

**5. Indicate the precautions related to the child’s medical/developmental condition that may impact the safe use of the device:**

- a. Document all confirmed and prospective contraindications for use of the selected device category; and
- b. Document how the child’s medical conditions and developmental status will affect how the device is used and/or how often it is used.

**6. Describe how the ATD category will be integrated into the child’s and the family’s natural routines (include the settings where the device will be used, the routine activities, and the frequency with which the device will be used):**

- a. The Individual Rendering Provider is required to assess and document how the ATD category will be used within the context of the family’s natural routines, and with respect for the family’s cultural, physical and social environments.
- b. In selecting a device category, the following criteria must be considered:
  - i. When the device category will be used by the child in each of a variety of settings (at home and in the community);
  - ii. How safety concerns will be addressed so that the device category will be safely used within each setting, including how it will be transported safely; and
- c. When the device category provides a dual function, (e.g., a seating device that also functions as a transport device, based on

an interchangeable accessory), documentation is required to illustrate the family's ability to modify the device for safe dual functionality and ease of use.

**7. What lower tech devices have you and the caregivers discussed or used prior to this request? Explain how they would or would not be appropriate for this child:**

- a. ATD ranges from low technology to high technology.
- b. The Individual Rendering Provider must document the process by which the device range or level was chosen. This documentation should include:
  - i. A discussion of which lower technology device was considered and, as appropriate, used by the child and family on a trial basis. Describe the outcome(s) of using the lower technology device.
  - ii. The rationale for why a lower technology device category is not being proposed.

**8. Identify any other ATD categories and/or adaptive items currently used by you, other Individual Rendering Providers, and parents/caregivers; and describe how the requested ATD category may be used with them and any other requested ATD devices:**

- a. Consideration must be given to any other ATD that the child may already have or will obtain, to determine whether multiple devices are essential to meet the child's functional outcomes, and, if so, to ensure compatibility of the devices or systems with one another.
- b. The Individual Rendering Provider is required to identify and document any device categories currently used with the child by:
  - i. The recommending Individual Rendering Provider (you);
  - ii. The other Individual Rendering Providers on the team; and
  - iii. The parents/caregivers/family.
- c. When a device category other than the one being requested now is currently being utilized, the Individual Rendering Provider is required to document:
  - i. How the requested device category will be used in conjunction with any current device; and
  - ii. Who will use the requested device with the child (other Individual Rendering Providers, parents/caregivers, others).

**9. Describe how you will collaborate with other Individual Rendering Providers (in the same setting or across settings) in the use of the proposed ATD category:**

- a. Document what was discussed with the other Individual Rendering Providers (and with any other service providers) about:
  - i. The child's use of the device category in applicable settings/locations;
  - ii. The family's routine activities in which the device category should be used;
  - iii. The child's functional abilities and skills that the device category is intended to support; and
  - iv. For the EI team members, the IFSP functional outcomes the ATD category will address.

**10. List the parents/caregivers that require training on the device, and list the specific items that need to be addressed in that training to ensure the parents'/caregivers' safe and functional use of the ATD category:**

- a. Who are the parents/caregivers that will be trained on the requested device category?
- b. List all of the areas that the training will cover, including precautions to ensure the safe and effective use of the device category.

**Signature**

The parent/caregiver and the Individual Rendering Provider are both required to sign this form. Please include the Individual Rendering Provider's license # and direct contact information, such as a cellular phone number. Do not write in the provider agency's phone number.