NYC Early Intervention Program Assistive Technology Medical Necessity Justification Form

Service Providers: The **requesting therapist** must complete this form for each device being requested and submit it to their **AT Agency Coordinator** for submission to the child's Service Coordinator. The requesting therapist must contact the TRAID Center via email: techworks@adaptcommunitynetwork.org with a completed **ADAPT Community Network TRAID Loan Request form** when the device being sought is within these categories: mobility, seating and positioning, to confirm their device loaner availability. No other device categories require TRAID outreach. The **AT Agency Coordinator** submits a complete AT packet: this completed form, the NYS prescription, and the **requesting therapist's** progress notes to the child's **Service Coordinator** within 3 business days of obtaining all of these required elements in order to support insurance billing. **Service Coordinators:** Submits the complete AT packet within 1 week of receipt from the AT Coordinator via Secure File Transfer (SFT) to the NYC BEI ATU at HIN ID: **ATUnit**, ensuring the AT packet is attached to the HCS SFT communication.

Child's Name: _____ DOB: _____/_____/_____

EI #: Service Type: Service Location:

Child's Diagnosed Condition(s): ICD-10 Code(s):

Individual Rendering Provider's Name: Credentials:

Can the child and caregiver travel to vendor location? ☐ Yes ☐ No

1. On what date did you email the TRAID Center Loan Closet? (required) _____

☐ TRAID will provide a short-term loan until the requested device, if approved, is ordered and delivered to the family.

☐ TRAID will provide a long-term loan for the duration of the child's anticipated use.

- Anticipated provision date:_____
- Anticipated length of loan:_____

☐ TRAID 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 their functional capabilities and meet their 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 Assistive Technology Device (ATD) 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. I also understand and agree that my child's Individualized Family Service Plan will be amended to authorize this ATD. This may include the authorization of evaluations and or services to support my child in obtaining and using this ATD.

Parent/Caregiver Signature: _____ Date: ____/____/____

Individual Rendering Provider Signature: _____ Date: ____/____/____

License/Certification #: Phone Number:

NYC EARLY INTERVENTION PROGRAM
ASSISTIVE TECHNOLOGY MEDICAL NECESSITY JUSTIFICATION FORM INSTRUCTIONS

GENERAL INSTRUCTIONS

The **requesting therapist** is required to complete this form for each device being requested, and to submit the completed form, with a copy of the child's most current progress note or amendment progress note if the last progress note for the child is more than 2 months old, to their agency's **AT Agency Coordinator** for submission to the child's **Service Coordinator**. The **requesting therapist** is also responsible to contact the TRAID (Technology Related Assistance for Individuals with Disabilities) Center via email (techworks@adaptcommunitynetwork.org) with a completed **ADAPT Community Network TRAID Loan Request: Mobility/Seating/Positioning Equipment form** to inquire about loaner device availability when the device being requested is a mobility, seating or positioning device. Documentation of the outcome of the discussion with the TRAID is required for these AT device categories to be considered for authorization by the New York City Early Intervention Program (NYC EIP). If the **requesting therapist** provides additional documentation to supplement this form, this must include the child's name, EI HUB ID, and the therapist's name, signature, and date.

The device will be considered for authorization when all the following are met:

- Requesting therapist documents a clear current individualized depiction of the child,
- Requesting therapist intends to continue to provide EI services and ATD oversight and training through and beyond the provision of the ATD,
- Device meets regulatory criteria and poses no harm to the child, and
- Complete AT packet is submitted more than 90 days before the child's 3rd birthday.

The following will not be accepted if included in the **NYC Early Intervention Program Assistive Technology Medical Necessity Justification Form**:

- An incomplete IFSP outcome not reflective of the ATD being requested and/or one that is not in compliance with a fully developed IFSP outcome generated with the family around ATD use. The structure of an IFSP outcome is outlined in www.nyc.gov/assets/doh/downloads/pdf/earlyint/ei-functional-outcomes.pdf.
- Templates used for previous submissions and or by authors other than the requesting therapist
- Generic documentation applicable to any child
- Citing formal sources instead of documentation that is individualized to the specific child
- Illegible, incomplete, irrelevant and or out-of-date submissions (submitted more than 3 months after documentation)
- Documentation reflecting a child prior to a critical incident (e.g., surgery, hospitalization, foster care placement) but submitted after the incident
- Documentation by a formerly treating EI therapist or a therapist who services the child outside of the NYC EIP
- Documentation by a current rendering NYC EI therapist whose services are anticipated to end within 4 months or less of the submitted request
- Submissions within 4 months of the child and family's anticipated move out of NYC
- Specific device recommendations, identified by manufacturer and or model, without detailed rationale describing how the exact device will offer unique benefit to the child unlike any other device in the same ATD category

Child's Name, EI HUB ID, DOB	Ensure all identifying information is correct. The EI HUB ID is the child's reference number identified in the EI HUB. Documentation in the NYC EIP **Assistive Technology Medical Necessity Justification Form** must match the information in the EI HUB (do not use alternate/nicknames).
Service Type, Service Location	Indicate the service type and service location where the requesting therapist's services are provided.
Child's Diagnosed Conditions, ICD-10 Codes	Indicate the child's diagnosed medical and/or developmental condition(s). ICD-10 codes are required to correspond to each diagnosed condition.
Requesting Therapist's Name, Credentials	Provide the name and credentials of the current rendering therapist who is completing this form and requesting this device (e.g., speech therapist: Speech/language Pathologist, MS, CCC/SLP). If you are a certified

	professional, indicate "certified'' but do not write the certification number. OTAs must include the license number of their supervisor.
Can the child and caregiver travel to vendor location?	Indicate whether the child and caregiver can travel to the selected vendor's office. Keep in mind: orthoses and amplification equipment orders are fulfilled at the orthotist's office and the audiologist's dispensary, respectively; durable medical equipment vendors conduct collaborations in the child's home. Requests outside of the New York State Department of Health Bureau of Early Intervention Fiscal Agent assignment requires documented explanation for the Fiscal Agent to consider.
The TRAID Center Loan Closet Techworks team: techworks@adaptcommunitynetwork.org	TRAID Center Loan Closets have a fluctuating limited inventory of mobility, seating and positioning devices specifically for children eligible for the Early Intervention Program. Equipment from this loan closet may be provided to the child and family on a short-term basis to determine the appropriateness of a device for the child. The availability of the device and timeframe of this loan is dependent on TRAID's resources as well as on the child's remaining time in the EIP. All devices loaned through the TRAID Center must be returned to the TRAID Center in accordance with their terms of the loan. Loaner requests are required to be submitted via email with the requesting therapist's completion of the **ADAPT Community Network TRAID Loan Request: Mobility/Seating/Positioning Equipment Form.**
Question #1: Contact with the TRAID is a required part of all mobility, seating and positioning device requests.	
1. On what date did you email the TRAID Center Loan Closet?	Indicate the date of your email to the TRAID Center Loan Closet. Check off one of the following outcomes and add the relevant information. The TRAID 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 loan timeframe (begin date to date device must be returned) c. The device is unavailable for short-term loan by TCLC
Questions #2 to #10: Document the ATD request and justify how it is necessary to maintain or improve the functional capabilities of the child and is medically necessary, if applicable.	
2. Requested ATD category. a. Indicate the category of ATD requested for this child. b. Refer to the below examples of commonly authorized ATDs, noting this list is meant to provide examples and is not exhaustive i. Augmentative and Alternative Communication (AAC): • Low technology and communication applications • Refer to **Appendix A: NYC Early Intervention Program Technical Assistance Document for Supplemental Evaluations for Audiology and Assistive Technology (Amplification, Augmentative and Alternative Communication, DME) for mid-and high-technology AAC guidance** ii. Durable Medical Equipment (DME): • Bath systems • Independent Mobility Devices • Adaptive Transport (pediatric wheelchairs) • Positioning Systems (standers; adaptive seating; orthopedic car seats) • Adaptive Toileting and Adaptive Potty Systems	

- Protective Helmets
- Unmounted and Mounted Head Supports

iii. Amplification:
- Hearing Aids
- FM Systems
- Required accessories

iv. Orthoses: Lower and Upper extremities and Orthotic custom-made and prefabricated garments

v. Vision: Prescription Eyewear

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. If the accessory is not known, describe the type of support the child will need to utilize the device.
b. Justify how each individual accessory or component is required for this child's safe and optimal use of the device, based on the child's functional abilities and skills.

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. The 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 \outcome(s) that will be addressed with the requested device category and any new outcomes that will be developed related to this device.
   ii. New outcomes are required to be written in the appropriate IFSP 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 mealtimes) 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 to 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 | mealtimes | 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 IFSP 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 ei-functional-outcomes.pdf (nyc.gov)

4. Describe how the ATD category will help the child increase, maintain or improve the child's functional capabilities and meet their unique developmental needs and the IFSP outcomes:

a. Document how the requested assistive technology device 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, supports the achievement of the IFSP outcomes and family priorities and, if applicable, is medically necessary.

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, how often it is used, and the related precautions to the child's use.

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 requesting therapist 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 not be appropriate for this child:

a. ATD ranges from low technology to high technology.
b. The requesting therapist 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 requested.

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 requesting therapist is required to identify and document any device categories currently used with the child by:
    i. The recommending requesting therapist (you);
    ii. The other service 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 requesting therapist 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 service providers, parents/caregivers, others).

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

a. Document what was discussed with the 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 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 who will be trained on the requested device category?
b. List all areas that the training will cover, including precautions to ensure the safe and effective use of the device category.

Signature: The parent/guardian and the requesting therapist are both required to sign and date this form. Please include the requesting therapist's license # and direct contact information, such as a cellular phone number. Do not write in the provider agency's phone number.