GENERAL ASSISTIVE TECHNOLOGY FUND APPLICATION

Individual's Name:	Contact Person:	Check all that apply:
☐ Jackson Class Member (contact CM, if unknown) DOB: Last 4 of SSN: Address: City/State/Zip: Home Phone:	 Phone: E-mail: Address: City/State/Zip: ☐Contact Person will purchase & deliver items approved. Initial box above	☐ receives DD Waiver funding (Jackson Class Members only)* ☐ waiting to receive DD Waiver Program support ☐ individual's age is less than 18 years ☐ individual's age is 18 years or more ☐ receives Medically Fragile Program support ☐ receives Mi Via Waiver support ☐Other funding (DME, insurance, DVR, etc.) is not available. *ISP Cycle Start Date, if DD Waiver:_____

Background Information and Plan for the Use of Requested AT (attach additional page for explanation, if needed):

Relevant Diagnosis and Functional Limitations:		
With what functional activities would the requested AT Items assist?		
What adaptation or features of the requested AT items would assist the individual to participate in functional activities?		
	Signature:	**Date forwarded to CSB:**

Please include ALL information requested! Amount requested not to exceed $250 per individual per fiscal year or if more, must identify supplemental funding source. No more than $20 for batteries per fiscal year. Include photocopy of catalog page or website page where the item is available. No tax can be reimbursed. Receipts and any remaining monies must be forwarded to the Clinical Services Bureau within 30 days of purchase!

Quantity	Item #	Item Name and Descriptors	Price each	S/H	Total per item
				Grand Total	

Mail or Fax to DDSD- Clinical Services Bureau, attn. ATF Coordinator **5301 Central Ave, Suite 1700, Albuquerque, NM 87108 *or* Fax: (505)841-2987**

CSB Reviewer Section Only	Date request sent to State Fiscal Agent:
Total Amount Approved:	Comments:
Items Denied (if any):	
Signature: Date:	

AAC ☐ **ADL** ☐ **COMP** ☐ **ECU** ☐ **LSR** ☐ **MOB** ☐ **POS** ☐ **SWOP** ☐ **SWTCH** ☐ **OTHER:** _____