

# City Pro Group, Inc.

## Policy & Procedure on Assistive technology.

This policy is written for City Pro Group, Inc. Staff, Service coordinators, Interventionists and Evaluators to expedite processing and delivery of Assistive Technology items for eligible children.

It is based on the NYC EIP AT Forms and Procedure practices and is effective as of October 1, 2006.

### INTRODUCTION

New York City's Early Intervention Program provides the resources to identify a child's assistive technology needs, and, in most cases, will cover the cost of approved items. When it has been determined that a child will benefit from the use of specialized equipment, NYC will assist parents, service coordinators, and therapists to access the item. This chapter was developed to help parents, therapist and service coordinators understand the process for determining the need for AT. devices/items; how to document that need; and how to request authorization on the specifications of the devices. Many different people play a role in identifying, approving, and monitoring the acquisition of equipment through EI. There are numerous steps in the process. AT devices may have to be specially made and/or designed to fit the child.

### DEFINITION

An Assistive Technology Device (AT Device) refers to designed or customized equipment, materials, product systems, or other items, whether available commercially or fabricated which enhance the ability of infants or toddlers with developmental delays or disabilities to achieve the functional outcomes contained in an IFSP. An Assistive Technology Service is a service that directly assists a child with a disability and/or the child's parent in the selection, acquisition, or use of an assistive technology device. Conversely, medical equipment that might be provided to a child as part of routine health care (e.g. treatment for an acute condition resulting from an injury) or medical/technological products that are life sustaining and are needed for infants and toddlers for survival or which are necessary for continuing treatment of a chronic health condition (for example, nebulizers, oxygen, NG tubes) are medical/surgical supplies, and therefore are typically covered by Medicaid and private insurance, and are not considered AT devices.

For more specific information and guidance regarding the appropriate selection, use, and types of devices under the Early Intervention Program, please refer to New York State Department of Health Early Intervention Memorandum 99-1.

### WHAT IS AN ASSISTIVE TECHNOLOGY DEVICE?

Listed below are classes of items that may be considered Assistive Technology items according to the special needs of an individual child:

Devices to increase, maintain, or improve self-help skills and functional abilities related to daily living activities and routine. Examples include devices that assist with seating and positioning, such as side lyers and prone standers, and insertions and adaptations necessary to correctly position or support an infant or toddler in a seated position.

Devices to increase, maintain, or improve functional ability. Examples include orthotics, scooter boards, walkers, therapeutic strollers and wheelchairs.

Vision and hearing aids for children with diagnosed visual impairments and hearing impairment.

Devices to increase, maintain, or improve communication skills and development, consistent with the child's functioning level.

Devices to increase, maintain, or improve cognitive development. Examples include adapted toys, and switches with necessary connection to toys to enable an infant or toddler with disabilities to interact with their environment (e.g. adapted toys with auditory signals for infants and toddlers with visual impairment).

The need for assistive technology can be identified during the process of MDE by members of the MDE team, by interventionist, providing services for eligible child, by parent or by service coordinator.

If the child is Medicaid or Medicaid Managed Care recipient, by EI Agency (if AT is requested by therapist it is the Agency affiliated with the interventionist) should apply directly to Medicaid or Medicaid Managed Care to obtain AT device.

If Medicaid or Medicaid Managed Care denies the request, the item may be requested through NYC EIP. (See procedure below) The same procedure applies for non Medicaid children should be sent to NYC EIP.

#### DOCUMENTATION OF NEED FOR AT DEVICE:

The need for an Assistive Technology device or service must be documented in order for the device or service to be reimbursable by the NYC Early Intervention Program. The need for the device or service must be supported by functional outcomes as stated within the IFSP.

- A. In order to assess an assistive technology device through the Early Intervention Program, an evaluator or clinical/provider of service must make a recommendation to the parent and ongoing service coordinator.
- D. In order to obtain an Assistive technology device for a child receiving EI services, the EI Service Coordinator must submit by mail a completed specification packet to the Assistive Technology Unit.

The following information is needed in all cases to support an Assistive Technology request:

- a. An evaluation and/or letter of specification (see attachment I) from a therapist or audiologist specifying the requirements for the device or service and why the particular model/style or item was chosen. Specific requirements for AT items such as wheelchairs, mobility devices, hearing aid are attached.
- b. A physician's prescription indicating specifications. If a child is being seen by a pediatric specialist the prescription should be written by that person.
- c. The cost of all items, model chosen, and specific accessories must be included with specifications for those items. The NYC EIP reserves the right to suggest a more cost effective source for any item requested. CPG therapist and/or CPG service coordinator must obtain this information from the manufacturer or supplier if AT item.

Please be aware that as the purpose of Assistive Technology devices in Early Intervention is to help the child achieve outcomes as written on their IFSP, devices requested in less than three months from the time the child's age out date will not be approved as items/devices will not be received in time to achieve that purpose.

**If you are considering to request AT device for the child you evaluated, provide services or service coordination we strongly encourage you to contact City Pro Program Director or Administrative Director to help you to facilitate the process. Also please note that all specification forms are posted on our web site [www. Findcase.com](http://www.findcase.com).**

#### ASSISTIVE TECHNOLOGY UNIT

- A. The Assistive Technology Unit will review the packet in order to determine:
  - ◆ If the recommended item is an approved Early Intervention AT device.
  - ◆ If the device is appropriate for the child's functional capabilities.
  - ◆ If the functional outcomes noted in the IFSP are appropriate and attainable by the child as a result of using the device.
- B. Upon authorization by the Assistive Technology Unit, the device must be purchased by the provider agency of the recommending Early Interventionist/Therapist. All orders must be filled according to the written prescription.

- C. Please contact the Assistive Technology Unit for assistance in determining how to obtain reimbursement for materials for items that therapists plan to use to fabricate devices for specific children (e.g. splints, adaptive seating, etc.).

**REQUEST FOR ADDITIONAL EVALUATION:**

A request for an additional evaluation to assess the need and the specific kind of equipment an EI child could benefit from should be sent to the Borough Regional Office or to the Assistive Technology Unit. Documentation of the need for such an assessment should be part of the request along with the parent's signature agreeing to the evaluation.

**SPECIALIZED EVALUATION AND/OR DISPENSING SITES:**

Note that the following list of Early Intervention Provider Agencies have special expertise in evaluating, fitting and dispensing hearing aid items/devices and augmentative communication equipment. Other EI issues may also be used when appropriate. Please contact Program Director or Administrative director for info about these sites.

Although some hospital settings within the Metropolitan area such as Maimonides Hospital, Beth Israel Hospital and the Long Island College Hospital are not EI contracted sites, the audiologists from these agencies are often contracted by EI provider agencies to provide services and/ or dispense equipment for EI children. These sites are considered sub-contracted by the EI provider agency who remains responsible for the billing process of the AT order.

**TECHNOLOGY RELATED ASSISTANCE FOR INDIVIDUALS WITH DISABILITIES (TRAID):**

The New York State Office of Advocate for Persons with Disabilities Technology Related Assistance for Individuals with Disabilities (TRAID) in partnership with the New York State Department of Health's Early Intervention Program (DOH/EIP) are jointly funding 15 Regional AT Centers throughout New York State. These Centers are available throughout the state for families and provider agencies. They provide a number of services that educate the public about the existence, usefulness and kinds of assistive technology available to meet the needs of persons with disabilities.

The AT Center for the New York City region, the Technology Resource Center (TRC) at UCP/NYC provides information about accessing assistive technology devices for the birth to three population. An Information and Referral Specialist is available to answer your questions about assistive technology products. The TRC maintains a demonstration center for people to "test out" products and a Lending Library so visitors can borrow items. On loan are toys with adapted switches, books, tapes, catalogs and other items helpful for the early intervention population. Presentations can be arranged by the TRC staff and visits can be made to homes and other locations with advance notice.

The sites which cover the five boroughs of New York City are:

Individuals in Manhattan or the Bronx, contact: United Cerebral Palsy of NYC technology Resource Center/SHARE 120 E. 23<sup>rd</sup> Street, 5th Floor New York N.Y. 10010 Tel: (212) 979-9700 TTY (212) 475-0842 Fax: (212)260-7469

Individuals in Brooklyn, Queens or Staten Island contact: United Cerebral Palsy of NYC Technology Resource Center/SHARE 160 Lawrence Avenue Brooklyn, N.Y. 11218 Tel: (718) 436-7979 TTY:(718) 436-1450 Fax: (718) 435-0941

Contact person for both sites: Liz Voluz, M.S..SAS : (212) 979-9700 ext. 717

**When City Pro interventionist or service coordinator is requesting AT device, you will need to use the Assistive Technology Unit Table presented on page 4. Also please give a copy of this form to parents to monitor the steps in AT device process. This form is also posted on our web site for your convenience.**

**Assistive Technology Unit Table. Should be used by Parent, Service Coordinator and the Interventionist**

Child name \_\_\_\_\_ EI # \_\_\_\_\_ SC Name \_\_\_\_\_ Agency \_\_\_\_\_ Ph. \_\_\_\_\_ Fax \_\_\_\_\_  
 Therapist Name \_\_\_\_\_ Discipline \_\_\_\_\_ Phone \_\_\_\_\_ Agency \_\_\_\_\_ Ph. \_\_\_\_\_ Fax \_\_\_\_\_

Date initiated/ Date Completed	Activity	Responsible Party	Whom to call
____/____/____ ____/____/____	<b>1.</b> A practitioner or therapist discusses the need for AT with the family and ongoing service coordinator <b>OR</b> The evaluation team discusses the need for AT with the family and initial service coordinator <b>OR</b> The family discusses the need for AT with the service coordinator and therapist. The service coordinator may assist in fostering communication.	<b>Any of the parties listed below:                      Evaluation team, or                      Therapist, or Family, or                      Service Coordinator</b>	-CPGI Monitoring Department or child's SC. - If unsuccessful please contact, Program Director.
____/____/____ ____/____/____	<b>2.</b> A. A recommendation for specific device is made by the therapist, evaluator, or physician in consultation with the family. B. The service coordinator must be informed by the therapist of the need in order to monitor the process.	<b>Evaluator, therapist,                      physician.</b>	
	If the therapist or s coordinator is uncertain whether the recommended device is a reimbursable in the Early Intervention Program,		Call is ATU 212-219-5580
____/____/____ ____/____/____	<b>3.</b> Evaluation/justification of the need for the device is written by the therapist.	<b>Therapist, who sends the                      evaluation/recommendation to                      the service coordinator</b>	
____/____/____ ____/____/____	<b>4.</b> Consider borrowing from the TRAIID Center for short term use. (See attachment for the list of TRAIID Cntrs.	<b>Therapist</b>	Some vendors may also be able to loan items for a short time.
____/____/____ ____/____/____	<b>5.</b> Obtain child specific information and submit all according to the AT protocol (AT Specification Form) a. Prescription when needed; b. Specification(s) of item(s) and all components; c. Price of item(s) and all components; d. Vendor name and address, catalogue number, and date of catalog e. Arranges for vendor to measure/fit child if necessary f. Sends all information to service coordinator	<b>Therapist                      S/he also collaborates with                      service coordinator on                      obtaining prescription from                      MD.</b>	
____/____/____ ____/____/____	<b>6.</b> Ongoing service coordinator ensures that the therapist has obtained all the necessary information. OSC then submits all documentation to the ATU	<b>Service Coordinator</b>	
____/____/____ ____/____/____	<b>7</b> Assistive Technology Unit reviews packet to ensure completeness. If not complete, Assistive Technology Unit will return packet to SC for completeness.	<b>Service Coordinator</b>	
____/____/____ ____/____/____	<b>8.</b> Assistive Technology Unit reviews the complete packet; either approves or denies request. If denied, ATU will contact the service coordinator	<b>Assistive Technology Unit</b>	
____/____/____ ____/____/____	<b>9.</b> Provider agency of the recommending therapist orders the equipment and ensures that item is delivered while child is still in the EIP.	<b>Provider Agency, Therapist                      Overseen by SC</b>	
____/____/____ ____/____/____	<b>10</b> When equipment arrives, and correct fit is ensured, the therapist notifies the provider agency and submits page 4 of AT packet to SC who forwards to ATU (see attached)	<b>Therapist, Vendor and                      Service Coordinator</b>	
____/____/____	<b>11</b> Provider agency pays vendor and submits a bill to EI upon receipt of equipment.	<b>Provider agency</b>	

**NYC EARLY INTERVENTION PROGRAM  
ASSISTIVE TECHNOLOGY SPECIFICATION FORM**

**SERVICE COORDINATOR MUST CHECK FOR COMPLETE PACKET.  
COMPLETE ALL INFORMATION REQUESTED.**

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**TO: Assistive Technology Unit**

**FROM:**

SC Name: \_\_\_\_\_

SC Provider Agency: \_\_\_\_\_

Contact #: \_\_\_\_\_ Fax #: \_\_\_\_\_

**RE:**

Child's Name: \_\_\_\_\_

EI #: \_\_\_\_\_ D.O.B: \_\_\_\_\_

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Attached is a request for Assistive Technology for the above-named child. A check mark in the appropriate box indicates that the specified item is included with this request.

- Complete and accurate justification of the AT need with signatures of the ordering therapist, doctor or audiologist, and the parent.
- Child insurance information
- MD prescription
- Complete and current IFSP-Packet
- Vendor information  
and/or
- Catalogue information

**Note:** The request packet must be legible, complete, and mailed to the address listed below.

Early Intervention Program – Assistive Technology Unit  
93 Worth Street, Room 915  
New York, NY 10013

I have verified that this request is complete and legible.

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**Signature of Service Coordinator**

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**Date Signed**

**NYC EARLY INTERVENTION PROGRAM  
ASSISTIVE TECHNOLOGY SPECIFICATION FORM**

Child's Name: \_\_\_\_\_ EI ID #: \_\_\_\_\_  
(Last) (First)

D.O.B.: \_\_\_\_/\_\_\_\_/\_\_\_\_ Borough: \_\_\_\_\_

Parent's Name: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_  
(Last) (First)

Address: \_\_\_\_\_

Child's Diagnosis: \_\_\_\_\_

**THERAPIST RECOMMENDING THE DEVICE:**

Name: \_\_\_\_\_ Discipline: \_\_\_\_\_

Agency Affiliation of the recommending therapist:

Agency Name: \_\_\_\_\_ Contact #: \_\_\_\_\_

Ongoing Service Coordinator: \_\_\_\_\_ ID #: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_ Fax #: (\_\_\_\_) \_\_\_\_\_

SC Agency: \_\_\_\_\_

**INSURANCE INFORMATION:**

Medicaid Eligible:  Yes  No Private Insurance:  Yes  No

Child's Medicaid or CIN #: \_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_

Child's Private Insurance Name: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group Name and #: \_\_\_\_\_

Device being requested: \_\_\_\_\_

Please indicate if assistance is needed from the AT unit in finding a vendor:  Yes  No

Please submit the specifications and cost of all items on either vendor or catalogue letterhead.  
 Include the following: name of item(s); list of accessory(ies); itemized cost of each item; shipping/handling charges; total charges; a picture of the device when available.

Is the device available for loan through TRAIID?  Yes  No

If yes, will the family be borrowing the device while this order is being processed?  Yes  No

Describe other A.T. equipment/devices that are presently used by the child and are found within the home environment:

NYC EARLY INTERVENTION PROGRAM  
ASSISTIVE TECHNOLOGY SPECIFICATION FORM

PAGE 2

Child's Name: \_\_\_\_\_ EI ID #: \_\_\_\_\_  
(Last) (First)

**DESIRED OUTCOMES** – Identify the functional outcomes expected to be attained by the child as a result of the use of this device/item during this IFSP period. Describe how the device/item will be used to accomplish these outcomes.

**PLAN FOR USE OF THIS DEVICE** – How will the device be used? Frequency and duration? By whom? In what setting (i.e. home, center)? If used by more than one therapist, specify goals for each discipline. Specify if parent will be using the device and any precautions or safety factors they should be made aware of. Indicate other AT equipment in the home. Does this item replace/supplement other equipment?

**DURATION** – What is the anticipated period of time (months/years) device will be used by the child?

I have discussed with the family and other therapists (if applicable), the possible use(s) of this equipment as an integral part of the child's Early Intervention services as stated on the IFSP.

Therapist's Signature (name/discipline): \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Therapist's Name: PRINT \_\_\_\_\_

Parent/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**NYC EARLY INTERVENTION PROGRAM  
ASSISTIVE TECHNOLOGY SPECIFICATION FORM**

PAGE 3

**TO THE RECOMMENDING THERAPIST :**

*In an effort to expedite the EIP-Assistive Technology Specification process, please review your papers to be sure that the following considerations have been addressed: \**

**REQUESTED ITEM/DEVICE IS:**

- to be used to increase, maintain or improve self-help skills and functional abilities related to daily living activities and family routines.
- to be used within the home setting by all caregivers, not just by the EI interventionists.
- functionally appropriate for use within the child's household considering the item's bulk or size, weight and ease of family use.
- to be used to implement outcomes set for the child and family within the current IFSP time period.
- recommended in collaboration with the child's EI interventionist(s) team.
- not a duplication of equipment which was purchased for the child's use either by the NYC EIP or any other source. If this item is to replace a like item, reasons for replacement must be clearly documented.
- ordered through a vendor (or catalog order for small items) with whom the recommended therapist has had good working experiences.
- clearly defined and its uses fully clarified with the child's caregivers.

**DOCUMENTATION SUBMITTED CONTAINS:**

- clear documentation as to the need for the device.
- specific rationale for choosing the particular type of item being requested.

\* This page is not required for hearing aid device orders and/or orthotic orders.

NYC EARLY INTERVENTION PROGRAM  
ASSISTIVE TECHNOLOGY SPECIFICATION FORM

PAGE 4

TO BE COMPLETED BY THE RECOMMENDING THERAPIST AND SUBMITTED TO THE ASSISTIVE TECHNOLOGY UNIT BY THE SERVICE COORDINATOR UPON RECEIPT BY THE CHILD/FAMILY OF THE ASSISTIVE TECHNOLOGY DEVICE ORDERED:

**NOTIFICATION OF RECEIPT OF AT DEVICE:**

Child's Name: \_\_\_\_\_ EI ID #: \_\_\_\_\_  
(Last) (First)

Therapist's Name: \_\_\_\_\_ Discipline: \_\_\_\_\_  
(Last) (First)

Vendor who fulfilled order: \_\_\_\_\_

Date of receipt of item: \_\_\_\_/\_\_\_\_/\_\_\_\_

Item received in good condition:  Yes  No

If no, indicate problem and resolution of the problem:

**ATTACHMENT:**

Attach a copy of the signed merchandise receipt/packing slip where appropriate. If this is not appropriate, please indicate reason:

**SIGNATURES:**

Therapist: \_\_\_\_\_

Parent/Caregiver: \_\_\_\_\_