Assistive Technology Request

(Complete before IFSP review. See step two of Accessing AT and Audiology)

Child:

First: __________________Middle:______________Last Name: ___________________

Date of Birth: ______________________ Phone:________________________________

Parent Name(s):____

Address: ____

____

Service Coordinator: ____

Service Provider: ____

(Please print both names and provide at least one signature with date)

Assistive Technology service or product description

Statement of IFSP Outcome for which AT is necessary as support or intervention:

____

____

____IFSP date: ___________________

Name and manufacturer of equipment: ____

Model #:____________________Size:____________________Cost:________________

Name of equipment:____

Model #:___________________Size:_____________________Cost:________________

Are parents willing to use insurance benefit? _____YES _____NO

Name of insurance company: ____

Vendor or Catalog resource: ____

Is this the vendor preferred by third party payer? ___YES ___NO ___DON'T KNOW

****

Signature of AT Coordinator: _____________________________Date:______________

Purchase Order Number: __________ Contingent on insurance denial?____yes ____no

Sept 2003