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| *North Carolina Infant-Toddler Program* |  |

*Assistive Technology Funding Authorization*

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. Child’s Last Name Child’s First Name MI | | | | | | | | | | | | | | | | | | 9. Name and Mailing Address of Assistive Technology Device Vendor | | | |
|  | | | | | | |  | | | | | | | |  | | |  | | | |
| 2. Date of Birth |  |  | |  | | |  |  | |  |  |  | 3. Sex  1. Male  2. Female | | | | |  | | | |
|  |  |  | |  | | |  |  | |  |  |  |  | | | | |  | | | |
|  | Month | | | Day | | | | Year | | | | |  | | | | |  | | | |
| 4. County of Residence: | | | | | | | | | | | | | | | | | |  | | | |
| 5. Shipping Address -- Street or RFD | | | | | | | | | | | | | | | | | |  | | | |
|  | | | | | | | | | | | | | | | | | | Phone #:       Email Address: | | | |
| 6. City | | | | | | | | | State | | | | | Zip Code | | | | Name of Contact Person at Vendor Company: | | | |
| 7. Telephone # |  | | | | | | | Email: | | | | | | | | | |  | | | |
| 8. Name of Parent or Guardian: Last First MI | | | | | | | | | | | | | | | | | | 10. Family’s Assigned Sliding Fee Scale Percentage       % | | | |
| 11. List Device(s) Being Purchased  *(see attached quote*) | | | | | | | | | Identification Number of Device | | | | | | | | | Cost of Device | | Medicaid Rate, MSRP or Catalog Price | |
|  | | | | | | | | |  | | | | | | | | | $  $  $  $  $ | | Medicaid Rate MSRP Catalog  Medicaid Rate MSRP Catalog  Medicaid Rate MSRP Catalog  Medicaid Rate MSRP Catalog  Medicaid Rate MSRP Catalog | |
| 12. Total Cost for All Devices: | | | | | $ | | | | 13. Payment Authorization: | | | | | | | | | | |  | |
| Tax (if applicable): | | | | | $ | | | | Monthly CAP:       Amount to be paid by Insurance = $       N/A | | | | | | | | | | | | |
| Shipping and Handling: | | | | | $ | | | | Balance (Cost of device(s) **-** Insurance Pay)      **X** Sliding Fee Scale % **= $**      Amount to be paid by Family  Authorized for Payment to Vendor (Grand total – insurance & family portion) **= $**      ITP share of cost | | | | | | | | | | | | |
| **Grand Total:** | | | | | $ | | | |  | | | | | | | | | | | | |
|  | | | | | |  | | | **Total:**  Vendor and family have made arrangements for family to pay their portion directly to the vendor. CDSA Business Office (BO) to proceed with ITP cost only.  Vendor and family have made arrangements for family to pay their portion directly to the vendor. There is no ITP cost.  Proceed with Payment to Vendor after receipt of family portion of cost or  Wait for invoice from vendor | | | | | | | | | | | $      Family portion **+** ITP Cost  CDSA BO to place catalog order | |
| ***Audiology Requests Only:***  Authorization Period: From:       To:       (not to exceed one yr or child’s exit from NCITP)  Devices being authorized for payment: Ear molds (up to 8 per hearing aid) Batteries (up to 6 packs)  14. Insurance or Third Party  Does family carry health insurance on this child?  Yes  No  Did parents give permission for insurance to be billed?  Yes  No  Not Applicable (If No or N/A, skip to Section 16A below.) | | | | | | | | | | | | | | | | | | | | | |
| 15. Does this policy cover this service?  Yes  No  Unknown | | | | | | | | | | | | | | | | Does this policy cover this service?  Yes  No  Unknown | | | | | |
| Complete insurance information is required when applicable. | | | | | | | | | | | | | | | | Complete insurance information is required when applicable. | | | | | |
| PRIMARY INSURANCE | | | | | | | | | | | | | | | | SECONDARY INSURANCE | | | | | |
| Policy #: | | | Claims Address: | | | | | | | | | | | | | Policy #: | | | Claims Address: | | |
| Policyholder: | | | | | | | | | | | | | | | | Policyholder: | | | | | |
| Insurance Phone #: | | | | | | | | | | | | | | | | Insurance Phone #: | | | | | |
| 16A. Type or print Service Coordinator’s Name | | | | | | | | | | | | | | | | | 18. Name of Requesting CDSA [central office]  Financial Officer:  Address of Central CDSA Office: | | | | |
| 16B. Service Coordinator’s Signature | | | | | | | | | | | | | | | | |  | | | | |
| 17. Signature of CDSA Financial Officer (or designee) | | | | | | | | | | | | | | | | |  | | | | |
|  | | | | | | | | | | | | | | | | | Phone #: | | | | Date: |

Please accompany with this form all that are applicable:

* Completed catalog order form, Price statement from vendor, and/or Insurance documents (i.e. benefit exclusion, pre-authorization, denials etc.)