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| *North Carolina Infant-Toddler Program*  |       |

*Assistive Technology Funding Authorization*

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| 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 FamilyAuthorized 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.)