CHILD AND FAMILY CONNECTIONS
ASSISTIVE TECHNOLOGY APPROVAL REQUEST

Please print clearly, complete entire request form and include *only* required attachments. Incomplete request forms will be returned, which will result in a delay.

Submission Date: _____ CFC #: _____ CFC Phone: ___ / ___ - _____ Ext. _____ CFC AT Coordinator's Name: _____

Child's Name: _____ EI#: _____ Birthdate: _____ **Has this child had previous AT requests?** ☐ YES ☐ NO

Name of Diagnosis(es): (1) _____ ICD-10: _____ (2) _____ ICD-10: _____ (3) _____ ICD-10: _____

Medicaid Eligible? ☐ No ☐ Yes, *Medicaid # (9 digits):* _____ DSCC Status: _____ Date listed on enclosed equipment: _____

Enrolled Equipment Vendor's Name: _____ Ordering Physician's First/Last Name: _____

IDHFS provider #, found in Enrolled Provider list *(12 digits)*: _____ Physician's License # *(9 digits)*: _____

Street Address: _____ Street Address: _____

City: _____ State: _____ Zip Code: _____ City: _____ State: _____ Zip Code: _____

Phone: ___ / ___ - _____ Phone: ___ / ___ - _____

Name & discipline of team member (therapist) recommending equipment: _____

Name & discipline of team member (therapist) who will train parent on how to use equipment: _____

ITEM(S) REQUESTED	HCPCS	QTY	$ EACH	$ TOTAL
				$ 0.00
				$ 0.00
				$ 0.00
				$ 0.00
				$ 0.00
				$ 0.00
				$ 0.00

This section is for DHS– BUREAU OF EARLY INTERVENTION use only.

Revised Item Description	*HCPCS*	*Qty*	*$ Each*	*$ Total*	*IDHFS?*
					Y / N
					Y / N
					Y / N
					Y / N
					Y / N
					Y / N
					Y / N

Comments:

The following documentation must be included with this request. Please check what is included.

- ☐ IFSP sections: Cover Sheet, Section 2, & Section 3 outcome pages identified above
- ☐ Copy of **Dated & Signed** credentialed evaluator letter of necessity supporting request
- ☐ Copy of **Dated & Signed** Physician's Prescription or development necessity letter
- ☐ Copy of itemized vendor quote including options/accessories breakdown
- ☐ Picture & pricing of item(s) from manufacturer
- ☐ Copy of DSCC eligibility letter
- ☐ If hearing aids have been requested, attach copy of *CFC Consent for Release of Information for Children with Identified Hearing Loss* form with **initial** IFSP date entered.

Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, the Federal Family Educational Rights and Privacy Act, 20 USC 1232g, and the Health Insurance Portability and Accountability Act of 1996, information collected hereunder may not be redisclosed unless the person who consented to this disclosure specifically consents to such redisclosure or the **redisclosure** is allowed by law.

REQUESTS MUST BE SUBMITTED FROM THE CFC OFFICE BY MAIL OR BY SECURE WEBMAIL. FAXES WILL NOT BE ACCEPTED. WHEN MAILING, SEND THIS FORM AND REQUIRED ATTACHMENTS TO: DHS -BUREAU OF EARLY INTERVENTION, 823 EAST MONROE, SPRINGFIELD, IL 62701

R08/01/2016