HOW TO GET

ASSISTIVE TECHNOLOGY DEVICES
AND SERVICES FUNDED

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June 1995

Disclaimer

This guide should not be considered "legal advice." Persons wishing to pursue problems related to individual cases should consult their own attorney, professional organization, or the staff of the Disability Rights New Mexico for further information.

Reasonable efforts have been made to assure the accuracy of this guide. However, errors may have been made in the process of editing, revising, compiling, or reviewing. Further, this is an area of law and regulation which continues to grow and change, and certain material may be superseded by further developments or amendments.

Acknowledgements

This guide has been funded by a grant from the National Institute on Disability and Rehabilitation Research (NIDRR) through the New Mexico Technology Assistance Program (NMTAP). It has been compiled by the staff of the Assistive Technology Project of the Disability Rights New Mexico.

Distribution

Alternate Formats

This guide may be obtained in alternate formats upon request, including computer disk and audio cassette tape.

TABLE OF CONTENTS

DISABILITY RIGHTS NEW MEXICO FOR ASSISTIVE TECHNOLOGY PROGRAM

-Purpose of the Program

-Eligibility for Services

-What Can PAAT Do for You?

-How to Get Help

SELF-ADVOCACY

SPECIAL EDUCATION

-Introduction

-Definitions

-Individualized Education Program

-Independent Educational Evaluation

-Resolving Disputes Through Mediation

-Appeals

VOCATIONAL REHABILITATION

-Introduction

-Eligibility

Application Process

-IWRP - The Plan

-Appeals

PRIVATE INSURANCE COMPANIES

-Introduction

-Evaluations

-Supporting Documents

-The Fine Print

-Appeals

VA BENEFITS

-Introduction

-Who's Eligible

-Prosthetic Appliances

-Services and Benefits for Blind Veterans

-Appeals

MEDICAID

-Introduction

-Scope of Medicaid Coverage

-Prior Authorization and Medical Need

-The Doctor's Statement and Funding Justification

-Appeals

MEDICARE

-Introduction

-Scope of Medicare Coverage

-Appeals

SOCIAL SECURITY WORK INCENTIVES

-Introduction

-SSDI Coverage

-The SSI Trial Work Period

-Continuing Medicare Eligibility Under SSDI

-SSDI Work Subsidies

-Impairment-Related Work Expenses

-Countable Income Under SSI

-SSI and the Plan for Achieving Self-Support

-Continued Medicaid Eligibility Under SSI

-Appeals

ALTERNATIVE FUNDING SOURCES

-Private Corporations

-Private/Public Fund-Raisers

-Nonprofit Civic Organizations

-The Foundation Directory

-Wish Makers

-United Cerebral Palsy, Easter Seal Society, and Paralyzed Veterans, etc.

-Adaptive Vehicle Rebates

-Advocacy Organizations and Manufacturers of Assistive Technology

INTRODUCTION

People with disabilities -- whether they are pre-schoolers, senior citizens or in between -- are increasingly able to use Assistive Technology (AT) to improve their life or work functions. An AT device means any item, piece of equipment, or product system that is used to increase, maintain, or improve functional capabilities of individuals with disabilities. Examples are computer equipment, augmentative/alternative communications systems, hand controls, wheelchairs and walking aids, environmental control devices, and aids for daily living and working. AT services means any service that directly assists an individual with a disability to choose, get, or use any assistive technology device. While a wide variety of AT devices and services are available, many persons have trouble getting them. The purpose of this guide is to inform you about ways to get AT devices and services and how to resolve problems or denials in trying to get these devices and services.

Assistive technology devices and assistive technology services may be provided or paid for by schools, vocational rehabilitation programs, Medicaid, private health insurance companies and many others. However, these funding sources have their own rules and procedures for granting benefits to people with disabilities. It is important to be aware of the various requirements and options to pursue.

This booklet outlines how New Mexicans with disabilities can obtain funding for AT devices and services from special education programs, rehabilitation programs, the Department of Veterans Affairs, Medicaid, Medicare, Social Security, and private health insurance companies.

DISABILITY RIGHTS NEW MEXICO FOR ASSISTIVE TECHNOLOGY PROGRAM

Purpose of the Program

The Disability Rights New Mexico for Assistive Technology Program was established to protect and promote the rights of persons with disabilities to access assistive technology devices and services to the greatest extent possible.

Eligibility for Services

The PAAT program serves persons with disabilities who are, or would be, able to maintain or improve their functioning through the use of assistive technology, but have been denied funding or are otherwise having problems in obtaining these devices or services. Both children and adults are eligible for services.

What PAAT Can Do for You?

The PAAT program can help you advocate for yourself and family members, represent a limited number of people in cases of service or funding denials, and provide training or workshops for groups interested in obtaining assistive technology for people with disabilities.

How To Get Help

The PAAT program is a project of the Disability Rights New Mexico, a non-profit statewide advocacy and legal rights center for persons with disabilities. You may contact the PAAT program at:

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SELF-ADVOCACY

In the search for assistive technology funding, you might deal with any combination of representatives from insurance companies, government agencies and private, nonprofit organizations. It's important for you to know how to work with these organizations and how to get answers to your questions and concerns.

You are your own best advocate. However, if you're new to the funding process and would like assistance, the best way to begin may be to work with someone who already has experience with obtaining assistive technology funding. You can get in touch with an advocate through manufacturers, disability groups, other people with disabilities and their families, teachers or therapists. Many technology manufacturers and vendors also have Funding Coordinators, full-time employees who are knowledgeable about the funding process.

To participate fully in the assessment and funding process, you need to know what you're entitled to and who should provide it. Following are some of the basic questions that you and/or your advocate should ask of the programs with which you're working:

·What are the eligibility criteria for this program?

·Are assessment, training, follow-up and equipment repair included in funding

considerations?

·If an assessment is to be provided, does it take into consideration appropriate

assistive technology services?

·Who makes the decision to fund or purchase an assistive device?

·What are the funding limits?

·Are funding policies available in writing?

·What legislation governs this program?

·What are my rights under the policy, plan, regulation, or law?

·Is there an appeals process? If so, what is it?

No matter which funding source you're approaching, it's very important that you demonstrate and document the need for the technology you request. A doctor's prescription for the assistive technology plus a letter from a professional describing the necessity for the devices or services, will go a long way toward helping you make your case. Additional information that will be helpful includes: an outline of your functional skills and how they will be improved by the assistive technology you request; an explanation of the specific features of the requested technology that will meet your unique needs; and the specifications of the equipment, including its cost and a photograph or catalog picture. Keep a file of all information related to the assistive technology funding request.

If you are denied funding upon your initial request, realize that denial is not an end point. In fact, appealing funding decisions is quite common, and nearly every funding source has an established appeals process to which you can turn for re-evaluation of your case. Many appeals for assistive technology are successful.

These appeals processes depend upon written evidence to support your claims. From the beginning of your search for funding, keep copies of all correspondence and written notes from all phone calls related to your case. When you begin an appeal, find out why your request was denied. If it was because of a lack of information, find out what additional information is needed, and submit it directly to the person handling your request.

SPECIAL EDUCATION

Introduction

The Individuals with Disabilities Education Act, or IDEA, is a federal law requiring public schools to provide a free, appropriate public education for children with disabilities. IDEA provides for services for infants and toddlers, for children ages 3 and 4, and the special education needs of children between ages 5 and 21. The New Mexico State Department of Education's Vision Statement supports the right of a child with a disability to receive the services which promote growth towards increased independence and competence. It claims the ultimate goal for all persons is to live as full contributing members of society and that the services for children must be directed toward this goal.

Definitions

The New Mexico State Board of Education Regulation 90-2 clearly defines assistive technology devices and assistive technology services. An AT device means any item, piece of equipment or product system, whether acquired commercially off the shelf, modified or customized, that is used to increase, maintain or improve functional capabilities of children with disabilities.

AT services means any service that directly assists your child in the selection, acquisition, or use of an assistive technology device. The term includes: (1) the evaluation of the needs of your child, including a functional evaluation of your child in his or her customary environment; (2) purchasing, leasing or otherwise providing for the acquisition of assistive technology devices; (3) selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing or replacing of assistive technology devices; (4) coordinating or using other therapies, interventions, or services with assistive technology devices, such as those associated with existing individual educational plans and rehabilitation plans and programs; (5) training or technical assistance for your child or, where appropriate, for you as the parent; and (6) training or technical assistance for professionals (including individuals providing education and rehabilitation services), employers or other individuals who provide services to, employ or are otherwise substantially involved in the major life functions of children with disabilities.

In addition to specified assistive technology services, there are also related services that should be provided for a child if they are needed for a child to benefit from special education. Related services include developmental, corrective, and other support services, such as speech, physical or occupational therapy. These definitions were intended by the lawmakers to be broad and to allow for a wide variety of equipment and services to be provided to children with disabilities.

Individualized Education Program

Special education services under the IDEA are provided according to an Individualized Education Plan (IEP). There are two main parts to the IEP process. One is the annual IEP meeting at which parents and school personnel jointly make decisions about the educational program of a child with a disability. Although this usually takes place just once a year, you may request an IEP meeting whenever you believe that your child needs an AT device or service. The second is the IEP document itself, which is a written record of decisions reached at the IEP meeting. The IEP is a management tool that is used to insure that each child with a disability is provided with special education and related services appropriate to the child's special learning needs. If during the IEP meeting it is determined that the child should be evaluated for certain kinds of assistive technology services, it must be put in writing, followed up, and carried out. If you want the school to provide an AT device or service for your child, be sure this gets written into the IEP with a date and a responsible person. Bring someone along to give you support and help you focus on what you need to have written in the IEP. Remember to read it before you sign it.

The IEP serves as a communication vehicle between parents and school personnel and enables parents, as equal participants, to jointly decide what the child's needs are, what services will be provided to meet those needs, what the anticipated outcomes might be (what your child should learn), and how the child's progress toward meeting the planned outcomes will be evaluated. The IEP process is often dominated by teachers and school administrators, but it is important for you to participate as a partner in the process.

Independent Educational Evaluation

As the parents of a child with a disability, you have the right to obtain an independent educational evaluation of your child if you disagree with the evaluation obtained by the school system. For example, you may need to have an independent expert evaluate your child's need for an assistive technology device or service, if the school's evaluation shows no need for it. You may request an independent evaluation at any time, and it must be provided at public expense unless the school opposes the request by asking for a "due process hearing" (see below). If you obtain an independent evaluation at your own expense, the school is required to take the results into consideration when it makes its decisions.

Resolving Disputes Through Mediation

The school personnel in an IEP meeting may not agree that your child needs AT devices or services. You may be able to resolve such disputes through mediation. Mediation may be conducted by trained mediators or school system personnel not previously involved in your particular case. In many cases, mediation leads

to resolution of differences between parents and school personnel without the development of an adversarial relationship and with minimal stress. You can ask the school to arrange a mediation.

Appeals

There are two ways to appeal school decisions which you believe have been unfair or have the effect of denying your child a service that he or she needs.

State Complaint: School systems must comply with state and federal laws and regulations applicable to the Individuals with Disabilities Education Act. If you believe that your school is not in compliance, you may file a formal written complaint to the State Superintendent of Public Instruction requesting an impartial investigation to correct the alleged problems. Be sure to include the state standards and/or federal regulation that you believe are out of compliance. You may want to include a copy of the IEP in question. Be sure to state the name of the child, the child's school, address, and telephone number.

The complaint must be signed by you or your designated representative and contain a statement that the school system has violated a requirement of a federal statute or regulation that applies to a covered program. The complaint should also contain a statement of the facts forming the basis of the complaint including efforts, if any, to resolve the complaint. The State Department of Education will review the documentation, may conduct an independent onsite investigation, and make a determination whether the school system is violating a requirement of an applicable statute or regulation. The State Superintendent or designee will mail a written decision with explanations to the parties within 60 days of receiving the complaint.

Due Process Hearing: You may also request an impartial due process hearing by writing a letter to your local superintendent and to the state superintendent. This letter may be hand-delivered or sent by certified mail and specifically state the reasons for the request. Be sure to include the name of the child, the child's school, address, and telephone number. A hearing is an opportunity for both you and the school to present information, witnesses, and other evidence in a formal way to an independent hearing officer, who will then make a ruling based on the evidence and the law. You may be represented in a hearing by an attorney. Since there usually are strict time limits and written notification requirements, you need to be prepared for each step in the process. Procedures for a hearing are described in SBE Regulation 90-2, Standards For Excellence Compliance Manual, Special Education, which may be obtained from the State Department of Education. The regulation spells out how, when, and by whom the hearings are conducted and how a decision may be appealed and reviewed administratively. In addition to knowing the published procedures, you should follow instructions contained in any letter you receive or any agreement made with the school. If you are dissatisfied with the decision of the hearing officer, you may appeal to the State Department of Education, which will arrange for a review. If you are dissatisfied with the results of the State review, you have the right to file a lawsuit under the IDEA.

VOCATIONAL REHABILITATION PROGRAMS

Introduction

Vocational rehabilitation services help people with disabilities prepare for, find, and keep jobs. "Rehabilitation" means teaching and training a person who has a disability how to reach goals and how to learn new skills. Rehabilitation has several ideal goals. These ideals can provide a long term guide to how a rehabilitation program should deliver services. These goals of rehabilitation include independence, self-management, self-advocacy, and employment. Assistive technology devices could be provided to help you to achieve these goals. There are several programs that provide rehabilitation services. The State of New Mexico's Division of Vocational Rehabilitation (DVR) and Commission for the Blind are two of those programs. Both agencies have a variety of services designed to assist people to become more productive and independent. The Navajo Office of Special Education and Rehabilitative Services (OSERS) likewise has programs for its clients.

Eligibility

A person is eligible for DVR services if he or she has a disability that creates a substantial handicap to employment and if DVR service might help the person become employed. A person is eligible for the Commission for the Blind services if he or she is legally blind or has a condition that will lead to blindness. A person becomes eligible for services when he or she reaches "working age." If the person is still in school, then the school must work together with the vocational rehabilitation agency to provide "transitional services." Each agency has rules for becoming a client. A "client" is someone to whom the agency can provide services. To be "eligible" means that you qualify for services under the rules of the agency. If you do not qualify, you are not eligible and the agency cannot help you. It is important that you know what the rules are for becoming a client. You may apply for services by calling on a telephone, writing a letter, or visiting the office that serves your area.

Application Process

When you apply, an appointment will be scheduled for you to meet with a counselor. The counselor will explain the process and must inform you about your rights. The counselor will ask you for information about yourself and will use the information to decide your eligibility. All the information you give is confidential. The counselor may schedule you for a medical examination or review of documentation about your disability as well as certain types of vocational testing, such as psychological, aptitude, I.Q., or achievement tests. During the evaluation process, think about the types of equipment and services that will help you reach your rehabilitation goals. Ask questions about assistive devices and services from the

counselor as well as other people who may do evaluations for you. The evaluation will help define the AT services or equipment you will need.

IWRP - The Plan

Once you are determined eligible for services, you and your counselor will work together to write a plan, the individualized written rehabilitation program or IWRP. This is the program you will follow to meet the goals of preparing for and getting a job. If you want the rehabilitation agency to provide you with AT devices or services, be sure to put this in the IWRP. Do not sign the IWRP if you do not agree with it. If you have questions or concerns about your program, talk with your counselor.

You and the counselor can change the IWRP while you are in rehabilitation, if your needs change. You and the counselor must review the IWRP at least once a year. If your situation has changed, you may ask for a review of your program at any time. If you have problems with your IWRP that you and the counselor cannot solve, you can ask the Client Assistance Program (CAP) at the Disability Rights New Mexico for help.

Appeals

At any stage in the vocational rehabilitation process, you have the right to appeal any decision made by the counselor that you do not agree with, including a decision not to provide AT devices or services. First, thoroughly discuss the problem with the counselor. If you cannot reach agreement, ask to talk to the counselor's supervisor. The supervisor will listen to both sides and provide you with a written decision. If you do not agree with the decision, you may request an Administrative Review.

In the Administrative Review, you ask to talk with the Field Operations Director who supervises your counselor's supervisor. The Field Operations Director will listen to both sides and make a decision, which will be in writing. If you don't agree with the decision, you may request a Fair Hearing by writing to the agency Director.

You may request a Fair Hearing at any time without going through the Supervisory Review or the Administrative Review. However, it is advisable to go through those steps and try to solve the problem before requesting a Fair Hearing.

You must request a Fair Hearing within 45 days of any decision you wish to appeal. Make a request in writing to the Director of DVR or the Commission for the Blind and give your reason for the request. The Director will appoint a Fair Hearing Officer from outside the agency who will listen to both sides like a judge at a court trial. You may have a representative or attorney with you.

After the Officer has heard everyone, he or she will make a decision and write the decision in a letter. The Director of the agency can review the decision of the Fair Hearing Officer but he or she cannot change the Officer's decision except when the Officer made an error under the law. The decision of the Director is final unless you go to court.

PRIVATE INSURANCE COMPANIES

Introduction

Many health insurance polices, Health Maintenance Organizations (HMOs) and other medical plans cover AT devices and services. There are many ways in which you can use health insurance to pay for assistive technology devices and services and it is important to consider your options. Each should be tried and completed before trying some other options. Each insurance company or plan has its own procedures and policies. Learn about them and find out what has worked for others before asking for approval or asking to be paid back for something you have already bought.

Some assistive technology devices are included in many health insurance policies under the terms "durable medical equipment" (DME), "prosthetics" or "orthotics". Durable medical equipment is defined as items which have the following characteristics:

·Can withstand repeated use;

·Are reusable by other people;

·Are primarily and customarily used to serve a medical purpose;

·Generally are not useful to a person in the absence of illness or injury;

·Are ordered and/or prescribed by a plan provider and authorized in advance by the plan

medical director or designee.

Some policies will pay only for the initial purchase of durable medical equipment or prosthetic devices. Other policies may include refitting or repair of furnished assistive devices. Often there is a requirement for prior authorization from the insurance company before purchasing a device. Usually, there must be a determination that the equipment is medically necessary and appropriate and related to the medical needs of the recipient as well as furnished by a provider with the appropriate credentials. Sometimes it may also require that the least expensive appropriate alternative service or device be obtained.

Evaluations

Most health insurance plans make decisions about whether to approve or disapprove AT devices based on a written evaluation from a physician. Depending on what type of equipment or service is being requested, a written evaluation may have to be completed by a speech- language pathologist, physical therapist, or other service provider. These written evaluations can be fairly lengthy and can provide necessary information. Occupational therapists, or physical therapists, for example, can decide if you have the strength or movement needed to use a manual wheelchair or a communication device. These additional reports can be cited in the medical evaluation and included in the information submitted to the insurance company. Discuss with your doctor, nurse, therapist, or other health care provider the coverage of AT devices under your policy or plan. It will be helpful for you, when they are writing the evaluations for prior authorization, if they can refer to the criteria in the policies and rules for each covered item.

Supporting Documents

For AT requests to medical plans, the following supporting materials are strongly recommended:

1. Prescription and letter of medical necessity from the primary physician(s).

2. Evaluations for letter of medical necessity from various specialists.

3. Insurance claim form or policy information with company address and telephone number.

4. Letters of medical necessity from:

Occupational therapist

Physical therapist

Parents

Etc.

5. Client information, name, address, phone number, date of birth.

6. Itemized list of equipment, and descriptive literature.

It is important to know the right language that must be used in applying through various insurance companies. It is also important to realize not only what an insurance policy may cover, but also what it excludes from the coverage. If you have questions about the right wording to use for a particular policy, contact the assistive technology device provider or therapists who are familiar with the device and the correct wording to use.

The Fine Print

Remember that insurance policy rules are usually very specific and extremely precise. If a product is described inaccurately, or a claim does not include all the necessary paper work (documentation), the insurance company may not pay for it, even if the item is covered by the policy. An insurance company may phrase the reason for the rejection of the claim in technical or bureaucratic terms, which can be difficult for a consumer to understand. Insurance companies are very careful about how they phrase things because of potential legal implications. In addition, insurance companies generally process claims by computer, and there are only a certain number of coded sentences that can reasonably be placed on a computer. Thus, the reason for the claim rejection printed on the EOB (explanation of benefit statement) is likely to be in a very general, technical language. If an insurance company wants a letter from a medical doctor before it will pay a claim, for example, the EOB may contain a statement such as "documentation incomplete" or "not medically necessary."

A phrase such as "not medically necessary" may simply mean that the insurance company cannot further process the claim until the documentation is complete. In the meantime, the claim might be coded as "not medically necessary" in the computer, since the company can't verify that the equipment is medically necessary without complete documentation. Of course, it may also mean that the company has decided that the equipment is not really needed for a medical purpose.

Appeals

If your claim is rejected, your next step should be to find out the specific reason for the rejection of the claim. Insurance company representatives are usually quite willing to help consumers understand the claims process. If the insurance company representative who answers the phone isn't able to help, ask to speak with a supervisor. Most supervisors know the claims process very well. You must find out how your particular insurance company's claims and appeals processes work to get the needed AT devices and services.

VA BENEFITS

Introduction

The Department of Veterans Affairs provides a wide variety of assistive technology devices and services not only to veterans, but also to eligible spouses and children of veterans who died, are permanently and totally disabled, are missing in action or captured in line of duty.

Special restorative training is available to eligible children who have a physical or mental disability that prevents pursuit of an education program. This may involve speech and voice correction, language retraining, lip reading, auditory training, Braille reading and writing, and similar programs. Specialized vocational training is also available to an eligible spouse or child over age 14.

Who's Eligible

Eligibility for most VA benefits is based on discharge from active military service under "other than dishonorable" conditions for a minimum period specified by law. Men and woman veterans with similar service are entitled to the same VA benefits.

The Department of Defense issues each veteran a military discharge form, DD214, identifying the veteran's condition of discharge - honorable, general, other than honorable, dishonorable or bad conduct.

Certain VA benefits and medical care require wartime service. Service in 21 groups during periods that include World Wars I and II has been certified as active military service by the Department of Defense for purposes of laws governing VA. Depending on their periods of service, members of these groups are eligible for certain VA benefits.

The surest way to obtain current information on VA benefits and claims procedures is to call the nearest VA regional office. Counselors can answer questions about benefits eligibility and application procedures and refer you, when necessary, to other VA facilities, such as medical centers. VA facilities are listed in the federal government section of telephone directories under Department of Veterans Affairs. You can also contact a veterans service organization, such as Paralyzed Veterans of America.

Prosthetic Appliances

Veterans may be provided prosthetic appliances necessary for treatment of any condition when receiving hospital, domiciliary, or nursing home care in a VA facility. Veterans who meet the basic requirements for outpatient medical treatment may also be provided needed prosthetic services under certain conditions.

Services and Benefits for Blind Veterans

Veterans with corrected central vision of 20/200 or less in both eyes or field loss to 20 degrees or less in both eyes are considered to be blind. Services are available at all VA medical facilities through the Visual Impairment Services (VIS) coordinator. Blind veterans may be eligible for services at a VA medical center or for admission to a VA blind rehabilitation center or clinic. In addition, blind veterans entitled to receive disability compensation may receive VA aids for the blind. Benefits for blind veterans may include:

(1) A total health and benefits review by a VA Visual Impairment Services team.

(2) Adjustment to blindness training.

(3) Home improvements and structural alterations.

(4) Specially adapted housing and adaptations.

(5) Low-vision aids and training in their use.

(6) Electronic and mechanical aids for the blind, including adaptive computers and electronic devices.

Appeals

Persons applying for VA benefits ("claimants") have the right to appeal decisions made by a VA regional office or medical center. Not all decisions can be appealed but those dealing with compensation or pension benefits, education benefits, and getting paid back for unauthorized medical services are typical issues which may be appealed.

A claimant has 1 year from the date of the notification of a VA decision to file an appeal. An appeal is started by filing a "Notice of Disagreement" in which the claimant states his or her dissatisfaction and asks for an appeal. This Notice of Disagreement should be filed with the nearest VA facility.

Following receipt of the written notice, the VA will send the claimant a "Statement of the Case" describing the issue, facts, applicable law and regulations, and the reasons for the determination.

To complete the request for appeal, you must file a "Substantive Appeal" within 60 days after the date of the Statement of the Case, or within 1 year from the notification of the original determination, whichever is later.

The Board of Veterans' Appeals conducts the appeals program for the Secretary of Veterans Affairs and makes final decisions on appeals involving all benefits administered by the VA. You may be represented by a veteran's service organization, an agent, or an attorney. Cases appealed from the Board of Veterans' Appeals are heard by the U.S. Court of Veterans Appeals. This court is independent of the Department of Veterans Affairs. Decisions of the court may be appealed to the U.S. Court of Appeals for the Federal Circuit and to the Supreme Court of the United States.

MEDICAID

Introduction

Medicaid can pay for the medical needs of low-income persons and is perhaps the most important funding source for assistive technology. You may be eligible to receive Medicaid in several different ways. However, for most persons who require assistive technology, the primary way to obtain Medicaid eligibility is usually through Supplemental Security Income, or SSI. New Mexico residents who receive SSI are automatically eligible to receive Medicaid. However, in order for a disabled person to receive SSI, he or she must have a low income and limited resources. Ways to maximize the allowable income and resources are discussed later in this manual. Despite limitations on income and resources, it is still possible that you or your child might be eligible for SSI or Medicaid. For example, unlike SSI, Medicaid does not count the income of a step-parent, so some disabled children may be eligible to receive Medicaid despite step-parent income. It is also possible for you to own a home and still be eligible for SSI and Medicaid.

Children can also qualify for Medicaid coverage under much higher family income standards.

Scope of Medicaid Coverage

There are 11 "mandatory" medical services that New Mexico is required to provide as a condition of its participation in the Medicaid program. These mandatory services include: physicians' services; inpatient hospital care; outpatient hospital care; laboratory and x-ray services; skilled nursing facility services for persons age 21 and older; home health services for persons age 21 and older; early, periodic screening, diagnosis and treatment (EPSDT) for persons less than age 21; family planning services and supplies to individuals of child bearing age; nurse midwife services; rural health clinic services; and services to pregnant women.

Each state can also choose to provide any or all of a number of "optional" services. The most important optional services for the funding of assistive technology which New Mexico has chosen to include in its Medicaid program include: physical therapy; speech, hearing and language therapy; durable medical equipment; hearing aids; and prosthetic devices. Under the rules that control provision of these optional services, the state is allowed to determine the "amount, duration and scope" of the service that will be covered.

Many of the mandatory services as well as the optional services can be used to fund the purchase of assistive technology. However, for children up through age 20, EPSDT is the most useful service for purposes of acquiring assistive technology since Congress requires the states to provide all of the "optional" services to persons eligible to receive EPSDT, even if the State does not offer those optional services to other Medicaid recipients.

Prior Authorization and Medical Need

The eligibility process you use to get some of these services is called "prior authorization" or "prior approval." Prior approval requires that the care or service you want is shown to be necessary to meet a medical condition or need, and that it is the least costly yet appropriate means to achieve the desired result. This must be shown before Medicaid services can be provided. In New Mexico, most Medicaid beneficiaries must enroll in managed care plans (MCOs), so most services must be requested through your MCO.

The medical necessity requirement may be the most difficult part of the approval standard to satisfy. The requested service must be "medically necessary" as determined by prevailing medical community standards or customary practice and usage. Basically, medical necessity means that you have a need for "treatment" to overcome the functional limitations caused by a body organ or system which is not working. Medicaid services can also be provided to cure illnesses or diseases, to assist in recovery from injuries, and to lessen the effects of conditions that impair a person's ability to function normally.

The Doctor's Statement and Funding Justification

In order for you to establish that you have a medical need for an assistive technology device or service, you must obtain a statement from your doctor along with a "funding justification." The first step in this process is a doctor's prescription or statement indicating that the service is needed. The doctor's statement must describe the diagnosis and the condition that the device or service will address. For every claim, clinical diagnostic terms should be used to describe the impairment. If you are a member of an MCO, you need to find out what steps your MCO requires.

Prior approval for an AT device will also require a "funding justification." A funding justification is an explanation of how the device or service will treat your condition. The request must be explained in terms of how it will enable you to overcome or reduce functional limitations. The funding justification should describe how the device or service will help your rehabilitation by eliminating, lessening, or slowing the progress of the functional limitations caused by your medical condition. The justification must explain how the technology will change your ability to function and how it will improve your life. The

justification should also describe how the device or service will increase your independence, self-care, self-determination, personal safety, or integration into community or facility activities. The justification must also describe your current mental and physical health, and explain that you will actually be able to use the technology. If you are a member of an MCO, you need to find out what steps your MCO requires.

The funding justification should be submitted by a clinician qualified to provide the covered service. For example, a speech/language therapist should be used to support a request for an augmentative communication device. To improve the chances of approval, the professional experience of the clinician should be thoroughly described, and a copy of his or her resume could be included along with the description. The description should include the number of years of professional experience, an estimate of the number of persons evaluated or otherwise served, and a summary of experience related to assistive technology. If you are a member of an MCO, you need to find out what steps your MCO requires.

The clinician must also describe the recommendation for prior approval. The description should include the name of the person who referred the client, the client information reviewed prior to the evaluation, the clinical setting of the evaluation, the length of the evaluation, the evaluation protocol, and whether the evaluation process has led to previous Medicaid funding of assistive technology. If you are a member of an MCO, you need to find out what steps your MCO requires.

The clinician must also explain why your current assistive technology, if any, is not sufficient or appropriate to overcome your functional limitations allowing for more independent and normal activity. In addition, the clinician must have considered a range of technology as an alternative means to address your functional limitations. The clinician should also describe the benefit of the assistive technology. Finally, the clinician must state that he or she was aware of the duty to select the least costly yet appropriate device to meet your needs.

In the request for prior approval, the clinical professional should give all the necessary information to the "provider." The provider must submit the prior approval forms and be the primary source for additional information. For most assistive technology, the provider will be the vendor who sells the durable medical equipment. It will be the vendor who will complete the paperwork and submit it to Medicaid. If there is a question, the question should be directed to the clinical professional or to your treating physician. The clinical professional or treating physician should request that the vendor provide notice of the date the funding request was submitted to Medicaid, of any Medicaid requests for further information, and of the date of any decision.

Appeals

You have the right to appeal any adverse decision (denial of benefit or prior approval). A decision can be challenged in a "fair hearing." You may request a fair hearing either orally or in writing. However, in order to be considered timely, the request must be received by the New Mexico Human Services Department (HSD) no later than the close of business on the 90th day from the decision. You may file a fair hearing request for reasons including:

(1) your application is denied or not acted upon within 30 days;

(2) your assistance is reduced, terminated, withheld, or the form of payment is changed;

(3) you are "aggrieved" (harmed) by any other action affecting your benefits or participation

in the program.

If you are a member of an MCO, you also have a right to appeal a service coverage decision through the MCO's own "grievance" process. Even if you do this, you still have the right to seek a "Fair Hearing" at any time.

Fair Hearing Rights:

You have the right to be advised about the hearing; to receive help in preparing for or participating in the hearing; to have a hearing which fully safeguards your opportunity to present your case; to have prompt notice and implementation of the decision based on the hearing; and to be advised as to the availability of judicial review. You may make your own presentation at the hearing, or you may be represented by an attorney, friend, relative, or other spokesperson. HSD must give you the documents you need to prepare for the hearing; provide a sign language or other interpreter, if needed; and assist you to submit the hearing request. At the fair hearing, HSD must explain the reason for the denial. In turn, you must be able to explain why the request should have been approved. You may present written and oral statements and witnesses to support your position. You may also question the HSD's witnesses. Fair hearings are usually informal, and may be held in person, or be conducted by conference call. You should be notified of the date of the hearing at least 10 days before the hearing.

Most hearings are held by telephone.

Before a hearing, HSD will schedule an optional conference to discuss the issue concerning the hearing. You may be able to resolve the dispute at this conference. You may request a conference to discuss any adverse action you do not agree with. However, unless you make a written withdrawal of the fair hearing request, the fair hearing will still be held.

Following the hearing, a written decision will be issued. The decision may be to reverse the services denial and direct Medicaid to approve your funding request. The decision could also uphold the denial, or send the matter back to the original decision maker for further information gathering or other review. Should you disagree with the final decision, you have 30 days after the date of the decision to appeal by filing a notice of appeal with the clerk of the state district court in Santa Fe or the county in which your Fair Hearing was held.

MEDICARE

Introduction

If , like many New Mexicans, you have chosen to obtain your services through a "Medicare + Choice" managed care plan, your plan processes all benefits claims.

Medicare is an important funding source for assistive technology. Medicare is a federal health insurance program under which claims for benefits are administered by private insurance companies called "carriers" and "intermediares". You may qualify for Medicare if you are eligible to receive Social Security, federal retirement (if you retired on or after 1983), state retirement (if you retired on or after 1986), or Railroad Retirement benefits or disability benefits under those programs. If you became disabled prior to age 22, and if you are the disabled adult child of a Medicare recipient, or the adult child of a deceased Medicare recipient, then you may also be eligible to receive Medicare benefits. You may apply for Medicare at your nearest Social Security office.

Scope of Medicare Coverage

Medicare benefits and hospice care are divided into two parts. Part A covers hospital care, nursing home care, and home health care. Part B covers outpatient hospital care, physician services, physical therapy, durable medical equipment and prosthetic devices, and many other services. However, Part B will not pay for eyeglasses or contact lenses (unless after cataract surgery), and will not pay for hearing aids.

Part B requires an annual $100 deductible, and a 20% co-payment for most services and devices. In addition, physicians and suppliers of equipment may charge more than Medicare allows. However, some physicians and suppliers agree to provide services and equipment on an "assignment basis". Physicians and suppliers who provide services and equipment on an assignment basis accept the allowed amount that Medicare will pay for a service or device as payment in full. The allowed amount consists of an 80% payment by Medicare and a 20% payment from you as the beneficiary. Unfortunately, most DME suppliers have not agreed to assignment. This situation can be a considerable barrier to obtaining assistive technology, especially for expensive items such as custom or power wheelchairs. Accordingly, you should

always ask if a DME supplier or physician will agree to provide services on an assignment basis. Whenever possible, try to purchase DME from suppliers who accept assignment. Because there is no assurance that Medicare will actually reimburse you, it is important that you establish the likelihood of Medicare reimbursement prior to making a purchase. If you have Medicaid as well as Medicare, Medicaid pays your share.

Medicare will only pay for durable medical equipment if it is "reasonable" and "necessary." A DME device will be reasonable and necessary if it is the lowest priced item necessary to meet your medical needs. Your physician's report must justify your need for the item by describing your condition and how the recommended item will assist you. The item must also be on a list of approved devices. If an item is on a list of disapproved items, then your only choice will be to appeal. If an item is not on the approved or disapproved list, then the purchase might be approved if you can show medical need. If the purchase is disapproved, then your only choice is to appeal if you want Medicare to fund it.

Medicare will not pay for equipment which is normally used for non-medical purposes, even if the item has a medically related function. For example, air filters and air conditioners are not considered medical equipment because their primary and customary use is non-medical.

Medicare defines durable medical equipment as equipment that can withstand use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of an illness or injury, is appropriate for use in the home, and is necessary and reasonable for the treatment of an illness or injury or to improve the functioning of a malformed body member. All of these elements must be met before Medicare will approve a DME purchase or rental. It is important that you obtain good medical documentation of medical necessity and reasonableness. Your physicians and suppliers should provide detailed reports establishing the nature and extent of your functional limitations, and any therapeutic interventions that have been attempted in the past.

Appeals

It is possible to appeal Medicare denials.

If you are a member of a Medicare + Choice plan, your appeal goes to the plan, but all plan denials can be appealed to an independent agency.

If you are not in such a plan, here are the steps:

The appeal should begin by requesting that Medicare review the denial. The review can be started by writing a note or letter requesting a "review" under Part B, and a "reconsideration" under Part A. You have 6 months to request the review or reconsideration. When requesting either a review or reconsideration, a copy of the denial should be included along with the request. If you are not satisfied with the results of the Part B review under Part B you may request a "fair hearing." You have 6 months to request the Part B fair

hearing. If you are still not satisfied after a decision of the Medicare + Choice appeals agency, the fair hearing under Part B, or the results of a reconsideration under Part A, the next step is to request an ALJ hearing. The request for the ALJ hearing must be made within 60 days of the determination notice. For you to request an ALJ hearing, there must be at least $500 in controversy. If you are not satisfied with the ALJ decision, and if you have $1,000 in controversy, you have the right to ultimately file an appeal in federal court.

During the appeal process, it is very important that you pay close attention to the time deadlines specified in any correspondence you receive. As in the case of Social Security appeals, persistence often results in a reversal of the earlier Medicare denial, and you should be prepared to appeal any denial of coverage.

SOCIAL SECURITY WORK INCENTIVES

Introduction

You may be able to use Social Security "work incentives" to fund an assistive technology device. A work incentive might allow you to work and still receive Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI). Perhaps even more importantly, eligibility for SSDI and SSI also brings eligibility for Medicare and Medicaid, respectively.

It is important that you cooperate with the Social Security Administration in order to take full advantage of possible work incentives. You should promptly report any work activity to the Social Security Administration. Failure to report work activity could cause you to be responsible should there be a future overpayment. You should always report work activity in writing. You should also be sure to always keep a copy of your report. Reporting by phone should never be relied on since phone reports are often not transferred to your record.

SSDI Coverage

You should understand the differences between the work incentive rules for SSDI and SSI. SSDI benefits include disability payments and Medicare. However, unlike SSI, eligibility for SSDI is not based on income and has no restrictions on unearned income or resources. You may become eligible for SSDI if you have become fully insured by paying into the system for the required number of calendar quarters. In general, you will be insured if you have worked for 5 out of the most recent 10 years. If you are younger than 31, you may be insured even though you have not worked 5 out of the last 10 years. If you are legally

blind, you may also be eligible despite not having worked 5 out of the last 10 years. If you became disabled prior to age 22, and if you have a biological or adopted parent receiving Social Security, you may also be eligible under your parent's contributions. The minor children of a beneficiary, or the spouse of a beneficiary who is caring for a child under 16 (or a disabled child over 16), may also be eligible for SSDI and Medicare.

The SSDI Trial Work Period

If you already receive SSDI benefits and want to go back to work, a "trial work period" allows you to have unlimited earnings without affecting eligibility during 9 months of trial work. The 9 months need not be consecutive. A month becomes a month of trial work when your monthly earnings exceed $200. A month that could have been counted as a trial work month is not counted after 5 years. You can be entitled to another trial work period if a new disability claim is approved. The work done during the 9 trial work months is evaluated to determine your ability to perform "substantial gainful activity" (SGA). If you are able to perform SGA, then you will be found to be ineligible for further benefits.

SSDI benefits will stop after your 12th month of work, which includes the 9 trial work months, the month after your disability ends because of work activity, and 2 adjustment months. There is no limit on your earnings during the 10th, 11th, and 12th months of work. Most importantly, you can use the additional income received from the trial work period to obtain assistive technology devices, and to continue eligibility for Medicare.

Continuing Medicare Eligibility Under SSDI

Medicare is an important funding source for assistive technology. Your Medicare can continue if you return to work without regard to the amount of your earnings. You can receive at least 39 months of hospital and medical insurance coverage after the trial work period. You must pay the monthly premium for Medicare Part B (medical insurance) for any month during which you do not receive a Social Security check. Including the trial work period, Medicare Part A (hospital insurance) is free until the end of your 4th year of work. After your 4th year of work, you can continue to buy Medicare coverage by paying both the Part A and Part B monthly premiums. By continuing Medicare eligibility, you can protect your ability to obtain needed assistive technology in the future. It is important that you carefully read any letter you receive regarding your right to continue on Medicare and that you follow the instructions contained in the letter.

SSDI Work Subsidies

If you receive SSDI, you can deduct the amount of any "subsidy" from your total earnings. The remaining amount will be your "countable earnings." Subsidies include extra supervision or training, extra pay which is above the "reasonable value" of your work, and help from unpaid persons which enables you to work. If you work in a sheltered workshop, then you are almost certainly receiving a subsidy. However, you may also be receiving a subsidy if you are working for a family business and receiving job training or receive wages above the normal amount paid for the type or quantity of work done. If you are working under such special conditions, the value of any subsidies can be deducted from your "total" earnings to calculate your "countable" earnings. You should obtain assistance from your employer to claim any subsidy. The subsidy should be documented by your employer and explained to the Social Security Administration. A subsidy could allow you to continue to be eligible for SSDI and Medicare enabling you to purchase or obtain assistive technology.

Impairment-Related Work Expenses

If you receive either SSDI or SSI, then you may be able to deduct your "impairment-related work expenses" (IRWE). An IRWE is the cost of an item or service which is related to your impairment and enables you to work. Impairment-related work expenses are an especially useful funding source for the purchase of assistive technology since you may also use the items and services for activities unrelated to your work. An IRWE could allow you to continue to be eligible for SSDI and SSI, as well as Medicare and Medicaid, enabling you to purchase or obtain assistive technology.

An IRWE can be deducted from your total pre-tax earnings provided that you actually pay for the item or service and that you are not reimbursed by other sources. An IRWE can be deducted by employees as well as persons who are self-employed. It is possible to average the cost of an IRWE over several months or for an entire year. However, the IRWE must be "reasonable." An IRWE will be reasonable if it is comparable to charges for the same item or service in your community. Examples of deductible expenses include:

1. Assistive technology devices such as wheelchairs, hemodialysis equipment, pacemakers, respirators, traction equipment, and orthopedic braces

2. Assistive technology related to work such as one-handed typewriters, page-turning devices, Braille devices, and telecommunication devices

3. Transportation costs related to work such as drivers or cabs (if such special transportation is not generally needed by unimpaired individuals), mileage expense for an approved vehicle, and wheelchair lifts

4. Services such as readers, interpreters, and job coaches

5. Other items such as expenses related to a guide dog

6. Medical costs such as drugs, prescribed medical treatment or therapy that is necessary to control a disabling condition, and the physician's fee relating to these services

7. Diagnostic procedures (including assistive technology) if the objective is related to the control, treatment, or evaluation of a disabling condition

8. Other assistive technology devices when such devices are essential for the control of a disabling condition (either at home or at work) such as an electric air cleaner for an individual with severe respiratory disease

Again, the cost of an IRWE must be actually incurred and must enable you to work. Any IRWE claimed which does not enable you to work, such as a prosthetic device that is primarily for cosmetic purposes, home modifications (if you do not work in the home), or medical expenses for minor physical or mental problems, cannot be deducted as an IRWE. It is important that any IRWE claimed by you be fully documented and, in the case of medical equipment or services, be supported by a physician. Along with your earnings report, you should notify the Social Security Administration of any IRWE you intend to claim.

Countable Income Under SSI

Unlike SSDI, SSI eligibility is based on financial need. However, some financial resources are not counted in determining SSI eligibility. For example, if you own tools or other equipment which enable you to work, the value of the tools or equipment is not counted. If the amount of your countable income is zero, then you would be entitled to Medicaid and the maximum SSI monthly payment. Accordingly, you should take care to establish the lowest possible countable income.

Income of $20 is a general exclusion and is not counted. If you are a student, then up to $400 a month of earned income (to a maximum of $1,600 a year) is not counted. In addition, the next $65 of any earned income is not counted. Of the remaining earned income, 50% is not counted. Also, an amount of earned income equal to your impairment-related work expenses is not counted. Income placed in a "special needs trust" may also not be counted. Finally, income put aside in an approved plan for achieving self-support is not counted.

SSI and the Plan for Achieving Self-support

Perhaps the most useful work incentive for purposes of obtaining assistive technology is the "Plan for Achieving Self-Support," or "PASS." You can use a PASS to purchase needed assistive technology while maintaining eligibility for SSI and Medicaid. Of course, the continued Medicaid eligibility can also enable you to obtain medically-related assistive technology.

The purpose of the PASS is to allow you to accumulate income and resources which can be used to help you to become self-supportive. Income and resources that are included in a PASS are not counted against you. However, the income or resources in the PASS cannot be used to buy food, clothing, or shelter. The funds placed in the PASS can only be used for purposes approved by Social Security and listed in the PASS. In addition, there is no limit on the funds you can exclude in a PASS. However, because you are paying for the item or service excluded in the PASS, it is to your benefit that you first be certain that the item or service cannot be purchased by sources such as Medicaid, private health insurance, DVR, or your employer.

You can create a PASS in cooperation with your Social Security case worker. Because few Social Security case workers are familiar with PASS, you may need to help him or her become more familiar with PASS. However, your case worker is required to assist you in the creation of the PASS. In order to have your PASS approved, you must develop a specific plan designed to achieve the goal of becoming self-supportive. A letter from your DVR counselor might help to support the feasibility of your goal. The PASS must also identify the income and resources to be contained in the PASS. For example, you might be receiving both SSDI and SSI. In such a case, you could designate the SSDI to be in the PASS which could cause your monthly SSI to be increased to the maximum amount. The exempted SSDI could be designated for the purchase of a van, attendant care, or other item identified in your PASS which would help you to become self-supportive. It is very important that you maintain complete records of all financial transactions. You should also maintain a separate bank account for the funds placed in the PASS. The PASS is designed to be flexible and it can be modified or extended to meet your changing goals or needs. You should contact your case worker if your goals or needs change. The initial length of a PASS is 18 months. However, a PASS can be extended for as long as 4 years. If your self-support goal changes, then you may be able to create a second PASS which could run longer than 4 years.

Continuing Medicaid Eligibility Under SSI

In New Mexico, Medicaid eligibility is linked to receipt of SSI benefits. However, under section 1619(b), your Medicaid eligibility can continue if your SSI has stopped because of work. To qualify, you must continue to be disabled, need Medicaid in order to work, be unable to afford benefits equivalent to the SSI

and Medicaid coverage, and meet all other SSI requirements. If you wish to continue to receive Medicaid, then you must meet with your SSI case worker and request to be allowed to remain on Medicaid.

Appeals

You may appeal any Social Security decision with which you do not agree. If you have been denied eligibility or been charged with an overpayment, then the Social Security Administration will send you a letter informing you of the denial or overpayment. This letter will also describe your right to appeal should you disagree with the decision. It is important that you read the letter carefully and file any appeal within the specified deadline. You may decide to request a hearing before an administrative law judge (ALJ). It is very common for the ALJ to reverse an earlier unfavorable decision. The ALJ hearing is designed so that you do not have to be represented by a lawyer. However, a lawyer (or other advocate) may be able to better develop and argue your case. Subject to the approval of the ALJ, the person who represents you is allowed to charge up to 25% of the amount of any back benefits. There may be other agencies, such as Legal Aid, which may accept a Social Security eligibility or overpayment case without charging a fee.

If Social Security has denied approval of a work incentive such as a proposed PASS, the first appeal step will probably be to request a meeting to discuss the decision. If you have been charged with an overpayment, you could use this meeting to request that the overpayment be waived.At this meeting, you may give reasons why you do not agree with the decision, or why the waiver should be granted. If your request is still denied, you could next ask for a written decision from which you could begin the formal appeal process.

ALTERNATIVE FUNDING SOURCES

In addition to the most common government programs and private health insurance plans described earlier in this manual, there are a variety of alternative or "creative" ways to obtain funding for assistive technology devices. Some people may be uncomfortable with approaches which may place persons with disabilities in the position of being subjects of charity. The alternatives below are simply offered as possibilities for people to consider if other funding sources are not available.

Private Corporations are a possible funding source. The purchase of equipment for a local resident by a small business can be beneficial to the business as well as to the individual. The benefits to the individual are obvious. The benefits to the company may include a tax write-off and positive local exposure. To gain the tax benefit, the donation for an individual may have to be made to an IRS-recognized tax-exempt organization. To gain favorable publicity, a direct gift to an individual (if they agree to it) may have the

greater impact. This approach may be particularly advantageous if a company needs to boost its public image.

Private/Public Fund-Raisers may assist in the purchase of assistive devices by sponsoring private or public fund-raising activities. Church members, co-workers, and members of other organizations (such as labor unions) have successfully raised funds to assist families in purchasing needed equipment by conducting raffles, bake sales, dinners, and a host of other creative methods designed to raise money.

Nonprofit Civic Organizations such as the Kiwanis, Rotary, Variety, and Lions Clubs have often contributed to the purchase of equipment. They commonly offer to match contributions from other groups, so it is best to request funding from several organizations.

The Foundation Directory lists funds and foundations and is organized by state and city. The directory should be available at large libraries. It is best to approach local foundations first since larger (national) foundations such as the Ford Foundation receive many requests for funding, while local funds may sit untouched for years because people are not aware of them.

"Wish Makers" are individuals and organizations which "grant wishes" to people who have specific needs. Two such organizations are listed below.

-Percy Ross is a multi-millionaire who grants wishes to people via a newspaper column which runs in papers across the country. The process involves writing to him with your request in care of the newspaper in which his column runs.

-The Sunshine Foundation is an organization which grants wishes to children with chronic disabilities. There is a limit of one wish per child in his or her lifetime, an application must be completed, and there is a maximum amount which will be funded. Families should initiate contact with the Sunshine Foundation National Headquarters.

United Cerebral Palsy, Easter Seal Society, Paralyzed Veterans, etc. typically provide funding which benefits many people at a time. There have been some cases, however, in which they have donated or contributed to purchases for individual needs.

Adaptive Vehicle Rebates in cash, roadside assistance and communication equipment are provided by manufacturers on new vehicle modifications. Consult the Chrysler Corporation, Ford Motor Corporation, General Motors Corporation and Volkswagen of America, Inc. for details of their programs.

Advocacy Organizations and Manufacturers of Assistive Technology are also valuable sources of funding information. They may be able to put you in contact with families who have purchased equipment and successfully found funds. These families may share their methods with you. Some manufacturers have special payment plans or offer low-interest loans for their products.