ASSISTIVE TECHNOLOGY REQUEST
AUTISM SPECTRUM DISORDER (ASD) WAIVER ONLY

DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 688 (2-2025)

Clear Fields

Name of Child	Telephone Number	Date	
Address	City	State	ZIP Code

Item(s) Requested	Vendor Location and Contact Information	Estimated Price(s)

Item(s) must be specified within the waiver care plan to include how the item will be used to increase, maintain or improve functional capabilities of participant.

Attachments which must accompany this request:

- Participant care plan to include item requested and what need is being addressed
- A professional recommendation to include evaluation of assistive technology with functional evaluation

By typing my name below, I am signing this application form electronically. I agree that my electronic signature is the legal equivalent of my handwritten signature. I attest, subject to the penalties of perjury that I am the individual completing this application and that I have provided accurate information.

Recommended By

Professional Signature	Date
Parent Signature	Date

Office Use

Check One ☐ Approved ☐ Denied	Signature	Date