# ASSISTIVE TECHNOLOGY AUTHORIZATION - AUTISM WAIVER

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES
SFN 1976 (11-2018)

Clear Fields

| Name of Client (Last, First) | | Medicaid ID | Date of Birth |
|---|---|---|---|
| Authorization Period<br>Begins: Ends: | Region | Screening Date | Name of Legal Guardian |
| Agency | | Name of Service Manager | |

| | Total for Quarter |
|---|---|
| **Assistive Technology** | |

**Right to Appeal, Denial, Reduction or Termination:** Your need for self-directed supports has been reviewed based on the following criteria: 1) degree of disability and specific support needs, 2) family stress, 3) availability of information supports, 4) need for a specially trained caregiver, and 5) risk of out-of-home placement. The above criteria are outlined in North Dakota's Home and Community Based Services waiver. If you disagree with the proposed individual budget, you may request a hearing before the North Dakota Department of Human Services. 42 CFR (Code of Federal Regulations) Subpart EE provides an opportunity for a fair hearing to any person if the state agency takes action to suspend, terminate or reduce services of Medicaid eligibility or covered services. Please contact your autism services unit manager for instructions on how to request a hearing. You must request a hearing in writing within 30 days of the date of this notice. Hearing requests must be forwarded to: Appeals Supervisor, North Dakota Department of Human Services, 600 E. Blvd, Ave, Dept. 325, Bismarck, ND 58505-0250. You may represent yourself at the hearing or you may have an attorney, relative, friend or any other person assist you. If you request a hearing before the date of action, we will not terminate or reduce services until a decision is rendered after the hearing, or you withdraw the request for a hearing, you fail to appear at a hearing, or it is decided that the only issue in the appeal is one of federal or state law/policy. You are advised, however, that if the hearing decision by the Department of Human Services is not in your favor, the total additional amount paid with Medicaid funds on your behalf may be considered an overpayment subject to recovery.

I agree that the amount authorized in this individual budget will allow me to meet the health and safety needs of my child or ward. I understand that I must work cooperatively with my fiscal agent and autism program manager and follow all Autism Spectrum Waiver policies. I also agree to submit all billings by the date specified for each contract period (July-September by October 31; October-December by January 31; January-March by April 30; and April-June due by July 10.)

| Signature of Legal Guardian | Date |
|---|---|
| | |

**Attach recommendation letter, purchase request and participant service plan.** ☐ check here to confirm attachments

**APPROVAL**

| Approved by State Autism Coordinator | Date |
|---|---|
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