AUTHORIZATION - AUTISM WAIVER
Assistive Technology - Community Connector - Remote Monitoring

DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 1976 (2-2025)

Clear Fields

For Assist Tech: Attach recommendation letter, purchase request and participant service plan.

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

Assistive Technology *Total For Quarter*

Item	Cost	

Community Connector *Total For Quarter*

Activity	Cost	
Supplies/Resources	Cost	

Remote Monitoring Service *Total For Quarter*

Starter Kit (device)		Cost	
Monthly Subscription Cost per Month	Number of Subscription Months	Cost	
One Time Activation Fee		Cost	

Total of all Services

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 understand that I must work cooperatively with my Service Manager and the Autism Specialist to obtain the requested and approved Assistive Technology. I understand that I must sign, date and return the authorization to the Service Manager for processing, but this signature does not affect my right to appeal.

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.

Signature of Legal Guardian	Date

APPROVAL

Approved By State Autism Coordinator	Date