Assistive Technology
Funding Avenues
In North Dakota
Winter, 2001

This is a publication developed by the North Dakota Interagency Program for Assistive Technology (IPAT) which supports people with disabilities, including those changed by the aging process, who require assistive technology devices and/or services.

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Interagency Program for Assistive Technology  
Judith A. Lee, Director  

Winter 2001  

Dear Friend:  

Assistive Technology Funding Avenues in North Dakota has been developed in response to statewide consumer request. Information contained in this document has been reviewed by agency personnel for accuracy of content and by consumers and others for content and readability. Policies and regulations are often changing; therefore, information in this document may have been altered since publication and some information may not be included. The Interagency Program for Assistive Technology maintains current data regarding policies and regulations relating to assistive technology and is available to address any questions that arise. Comments concerning the usefulness of this Guide are welcome and will be considered when futures editions are developed.  

The Interagency Program for Assistive Technology is a program of the North Dakota Division of Vocational Rehabilitation, Department of Human Services. Initiatives and activities are guided by the IPAT Consumer Advisory Committee (CAC).  

We hope you find this funding information helpful. Additional copies of this Guide, in addition to enlarged print, audio, and Braille versions, are available without charge to North Dakota residents by contacting the IPAT Central Office at 800-265-IPAT (4728).  

Judie Lee  
IPAT Director  

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INTRODUCTION

Technology is everywhere. Our lives are constantly touched by its presence. From the snooze alarm at day’s beginning to the click of the light switch at day’s end, people use technology to make their lives easier. However, for people with disabilities and for those changed by the aging process, access to technology is a key to independence!

ASSISTIVE TECHNOLOGY

Although assistive technology (AT) is referred to under many names (rehabilitation technology, durable medical equipment, or daily living aids), Congress chose to provide specific definitions for assistive technology devices and services in a number of Federal acts, including the Technology-Related Assistance for Individuals with Disabilities Act of 1988, the Technology-Related Assistance for Individuals with Disabilities Act Amendments of 1994, the Rehabilitation Act, the Individuals with Disabilities Education Act 1997, and the Assistive Technology Act of 1998.

What is an Assistive Technology Device?
Federal legislation defines an assistive technology device as:

“. . . any item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of individuals with disabilities” [20 U.S.C. Chapter 33, Section 1401 (25)].

An assistive technology device, therefore, could include any item, which would enable an individual with a disability to function more easily or more independently at home, at school, at work, and during leisure activities. An assistive technology device may be as simple as a modified drawer pull or as complex as a sophisticated digital communication device or a thought-activated computer application.

What is an Assistive Technology Service?
As assistive technology service has been defined as:

“. . . any service that directly assists an individual with a disability in the selection, acquisition, or use of an assistive technology device. Such term includes—

A. The evaluation of the assistive technology needs of an individual with a disability, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the individual in the customary environment of the individual;

B. Services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices by individuals with disabilities;
C. Services consisting of selecting, designing, fitting, customizing, adapting, maintaining, repairing, or replacing assistive technology devices;

D. Coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with education and rehabilitation plans and programs;

E. Training or technical assistance for an individual with disabilities, or, where appropriate, the family members, guardians, advocates, or authorized representatives of such an individual; and

F. 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 individuals with disabilities.”

ABOUT THIS GUIDE . . .

Assistive Technology Funding Avenues in North Dakota has been designed to assist individuals with disabilities and their families in search of funding for assistive technology devices and services. Service providers, advocates, equipment vendors, and others will also find the information helpful.

This document provides descriptions of North Dakota’s major assistive technology funding sources. Each section contains a brief overview of the funding source, eligibility criteria which apply at this time, assistive technology funding potential, the application process, the appeals process, and contact information.

With this information it is anticipated that consumers and their families will more accurately identify appropriate funding streams, will understand the processes involved, and will have resources identified within each area from which to obtain additional information.

ABOUT IPAT . . .


The Assistive Technology Act of 1998 was passed reaffirming that technology remains a valuable tool to improve the lives of Americans with disabilities. It also affirms the federal role of promoting access to assistive technology devices and services for individuals with disabilities. The purpose of the law is to support
capacity building and advocacy activities designed to assist states in maintaining permanent, comprehensive statewide programs of technology-related assistance.

The Interagency Program for Assistive Technology (IPAT) is North Dakota’s Tech Act project. As such, IPAT is committed to and leads the state in developing strategies that reflect the goal of improving access, consistency, continuity, quality assurance, and cost-effective approaches to obtain assistive technology devices and services.

This goal will be realized through:

a) Interagency coordination which will develop and promote policies that improve access to assistive technology devices and services for individuals with disabilities of all ages;

b) Public awareness activities designed to provide information to targeted individuals relating to the availability and benefits of assistive technology devices and services;

c) Technical assistance and training which will provide support to public or private entities to develop local resources to increase consumer access to appropriate assessments, training, equipment, and funding for assistive technology; and

d) Outreach activities to regions of this rural and sparsely populated state, including a focus on Native Americans and older individuals living below the poverty level, the two population groups identified as underrepresented in North Dakota.

ACKNOWLEDGMENTS

North Dakota’s Interagency Program for Assistive Technology (IPAT) gratefully acknowledges the significant contributions of the North Dakota Protection and Advocacy Project to all sections of the Assistive Technology Funding Avenues in North Dakota. Sincere thanks, also, to those listed below who provided content within the specifically designated sections of the guide.

Assistive Technology Funding & Systems Change Project, United Cerebral Palsy Associations, Funding of Assistive Technology Booklet Series: Supplemental Security Income and the Family Law Attorney; Medicare, Managed Care and AAC Devices for HMO and Other Medicare + Choice Participants; Medicare and AAC Devices for Non-HMO Participants; The Public School’s Special Education System as a Funding Source for AT; State Vocational Rehabilitation Agencies and Their Obligation to Maximize Employment; and Using Work Incentives under Social Security and SSI to Fund Assistive Technology.

Doris Schell, Program Administrator, Medical Services Division, North Dakota Department of Human Services: Medicaid

Muriel Peterson, Administrator, SPED and Medicaid Waiver Programs, Aging Services Division, North Dakota Department of Human Services: Medicaid

Robin Hendrickson, Administrator of Adult Services, Developmental Disabilities Unit, Disability Services Division, North Dakota Department of Human Services: Medicaid

Cheryl Wescott, Program Administrator, Vocational Rehabilitation, Disability Services Division, North Dakota Department of Human Services: Vocational Rehabilitation

Guidelines: Assistive Technology for Students with Disabilities, North Dakota Department of Public Instruction: Education
VOCATIONAL REHABILITATION

The purpose of the Rehabilitation Act, under which Vocational Rehabilitation falls, is to develop and implement comprehensive and coordinated programs of Vocational Rehabilitation and independent living for individuals with disabilities in order to maximize employment, economic self-sufficiency, independence, and inclusion and integration into society. Programs of Vocational Rehabilitation include: the Client Assistance Program, Supported Employment, Services for the Older Blind, Independent Living Services, and Americans with Disabilities Act and Employment.

Vocational Rehabilitation is a public service financed by state and federal funds. The mission of North Dakota Vocational Rehabilitation (VR) is to provide the opportunity for individuals with disabilities to achieve productive employment and increased independence through rehabilitation services. Vocational Rehabilitation is an employment program for anyone who has a physical and/or mental disability that prevents him or her from going to work.

Any service an individual receives from VR must be connected to an employment goal. The employment goal can be full time or part-time, and must be consistent with the person’s strengths, abilities, interests, and informed choice, and can include competitive employment, self-employment, telecommuting, and business ownership as successful employment outcomes.

ELIGIBILITY
Any person who feels his or her physical or mental disability is a barrier to employment or independent living and who could benefit from VR services may be eligible for assistance.

To receive VR employment services, an individual:
- Must have a mental, physical, or learning disability that is a substantial impediment to employment; and
- Must require VR services to prepare for, secure, retain, or regain employment.

State rehabilitation agencies must presume that a person with a disability is able to work and can benefit from VR services regardless of the severity of disability, unless the counselor can clearly demonstrate otherwise. In other words, it is unlawful for state vocational rehabilitation agencies to automatically determine that a person cannot benefit from services because of the severity of the disability. The VR counselor must look at all options, including assistive technology interventions, before denying eligibility on that basis.

APPLICATION PROCESS
After contacting a regional Vocational Rehabilitation office in one of the
eight regional centers in North Dakota, some paper work must be completed. A VR counselor will provide help with paperwork completion, if needed, and will ask for permission to review reports from physicians and others. Unless an extension is agreed to, a person will be informed of their eligibility within 60 days following the application for services.

**Individualized Plan For Employment (IPE)**

An individualized plan for employment (IPE) is written for everyone who is eligible for services. The IPE identifies the employment goals, services that are needed, and steps to be taken to meet the goal.

The employment goal is based on the unique strengths, resources, abilities, priorities, and interests of each person. The VR counselor will assist in developing the plan and both the individual and the counselor sign it. This plan is reviewed at least once a year, but can be reviewed more often if necessary.

**ASSISTIVE TECHNOLOGY FUNDING SOURCE**

State Vocational Rehabilitation agencies may be a major assistive technology funding source for individuals of working age with disabilities. The IPE must contain a statement of the specific assistive technology device or service required by the individual to meet their employment needs.

Although consumers are not necessarily entitled to the assistive technology of their choice, becoming well-informed about technology options helps them play an active role in IPE development reflecting informed choice. Decisions regarding the types of assistive technology to be used must be based on the functional analysis of the consumer’s needs and the impact assistive technology has in increasing their functional employment capacities in terms of their vocational goal.

These decisions cannot be made on the basis of cost or the severity of the individual’s impairment. Assistive technology devices and services may not be excluded from the IPE because the consumer may be able to obtain funding elsewhere, nor because of insufficient funding.

Examples of services and devices which may be considered assistive technology include:

**Telecommunications, sensory, and other technological aids and devices:**
Adaptive equipment to aid communications and mobility; home modifications to include those which make one aware of and to be able to control one’s environment; work site accommodations and others.

**Physical and mental restoration services:**
Those services necessary to correct or substantially modify a physical or mental condition, which is stable or slowly progressing.
Eyeglasses and visual services, including visual training: Any assistive technology device or service which will aid an individual in seeing or reading.

Physical therapy, occupational therapy, speech, or hearing therapy: Obvious sources of assistive technology devices and services.

COLLABORATIVE EFFORTS SUPPORTING STUDENTS
For many students, the last years of education can, and should, consist of a combination of education and vocational training programs in which both the school system and Vocational Rehabilitation can be a part.

Both schools and Vocational Rehabilitation are mandated to provide transition services to assist students leaving the school environment.

This mandate requires a collaborative effort to determine the best AT devices and/or AT services and to assist in the provision of funding to meet this need.

CLIENT ASSISTANCE PROGRAM

The Client Assistance Program (CAP) has the responsibility to provide information and referral services and to advocate for those who are applying for or receiving services under the Rehabilitation Act. It helps access these services through both individual and systems advocacy.

CAP will provide advocacy, will act on your behalf by receiving and investigating all complaints, will assist in appealing a decision if you are dissatisfied with the denial or provision of services, and will provide confidential support.

Client assistance may be contacted with issues such as those found in the following examples:

- Undue delay in the processing of an application or services requested.
- Denial of eligibility or disagreement with a decision.
- Not receiving services to which you feel entitled.
- Problems with the program which have not been satisfactorily resolved through your counselor.
- Questions regarding the services and benefits available through the Rehabilitation Act.
- Problems with other agencies or training facilities which are presenting difficulty in attaining rehabilitation goals.

ELIGIBILITY

The Client Assistance Program is available to anyone who is applying for or receiving vocational rehabilitation services, services for the visually
impaired, independent living services, or other services funded by the Rehabilitation Act.

**APPEALS PROCESS**
A person applying for or receiving Vocational Rehabilitation services has the right to request a review of any decision relating to eligibility or service provision.

An appeal may be initiated through a regional Vocational Rehabilitation counselor or through the Client Assistance Program. Appeals can also go directly to the Appeals Supervisor at ND Department of Human Services, State Capitol, 600 E. Boulevard, Bismarck, ND 58505. An appeal must be initiated with 30 days of the decision unless the Client Assistance Program is involved.

**CONTACT INFORMATION**
For further information, contact the Client Assistance Program or Vocational Rehabilitation in one of the eight regional Human Service Center offices. See Directory: Client Assistance Program (CAP) or Vocational Rehabilitation.

**SUPPORTED EMPLOYMENT**
Supported employment provides employment opportunities for adults with the most severe disabilities, adults who have historically been excluded from employment because they were considered “too disabled” to work.

These services combine paid work with the supports that will allow them to maintain a regular job, and may include assistive technology. The supports include:

- Job development;
- Job matching;
- Job training; and
- Supervisor and/or co-worker training.

**CONTACT INFORMATION**
For further information, contact Vocational Rehabilitation in one of the eight regional Human Service Center offices. See Directory: Vocational Rehabilitation.

**SERVICES FOR THE OLDER BLIND**
The population assisted by this program is defined by statute as individuals who are fifty-five years of age or older and, because of their blindness or severe visual impairments, gainful employment would be extremely difficult to attain, but for whom independent living goals are feasible.
Vision rehabilitation specialists train people at home, on the job, and in their communities. Vocational Rehabilitation works cooperatively with the Department of Public Instruction in providing a center for adaptive skills training for adults with visual impairments. The Department of Public Instruction, through the School for the Blind in Grand Forks, also provides an adaptive technology and information center for all North Dakotans.

Services for Older Blind are funded through a combination of federal and state dollars. Each year the state receives funds under a formula from the federal government, which must be supported by a 10% state match. The North Dakota Association of the Blind has been able to obtain a small supplement of state money, which has been added to the required match.

**ELIGIBILITY**

Anyone who has a visual impairment, which constitutes a substantial handicap to independent living or employment, is eligible for services through the Vision Services program.

**ASSISTIVE TECHNOLOGY FUNDING SOURCE**

Specific services may include, but are not limited to, the following:

- Assistive technology;
- Diagnostic work-ups;
- Necessary corrective treatment, hospitalization, and nursing services;
- Adaptive aids, including those based on optical and non-optical technologies;
- Orientation and mobility training;
- Personal adjustment/daily living skills training;
- Skills training services which may be provided in the client’s home and community, or at a training facility.

**APPLICATION PROCESS**

The process by which to apply for vision services is similar in most respects to the traditional rehabilitation program process. Each individual completes an application and, if determined eligible, a plan is drawn up defining services to be provided.

**APPEALS PROCESS**

See the Client Assistance Program on page 7.

**CONTACT INFORMATION**

For further information, contact Services for the Older Blind. See Directory: Services for the Older Blind.
INDEPENDENT LIVING SERVICES

North Dakota’s independent living services assist individual’s with severe disabilities to be as independent and productive as possible at home, in their communities, and on the job. North Dakota sub grants its independent living services to four non-profit independent living centers. The centers are located in Bismarck, Fargo/Moorhead, Grand Forks/East Grand Forks, and Minot. There are presently out-reach offices in Dickinson and Jamestown. In addition to other services necessary for individuals to achieve their independence, each center provides the following four core services:

- Independent living skills training;
- Peer counseling;
- Information and referral; and
- Self and systems advocacy.

In North Dakota, the purpose of the Independent Living Program is to eliminate barriers and provide assistance to individuals with disabilities so they can live and work more independently in their homes and communities. Independent living has a philosophy of consumer control, peer support, self-help, self-determination, equal access, and individual and system advocacy in order to maximize the leadership, empowerment, independence, and productivity of individuals with disabilities and their integration into the mainstream of American society.

ELIGIBILITY

Independent living services may be provided to any individual whose ability to engage or continue in employment, or whose ability to function independently in the family or community, is so limited by the severity of the disability that independent living services are required to improve one’s ability to function more independently in the home, community, or on the job.

TELECOMMUNICATIONS EQUIPMENT DISTRIBUTION PROGRAM

Vocational Rehabilitation administers the Telecommunications Equipment Distribution Program. These services are provided through a contract with the North Dakota Centers for Independent Living. They provide telecommunication services to individuals with speech and hearing impairments that will allow them to communicate with family, friends, employers, and services within their community.

ASSISTIVE TECHNOLOGY FUNDING SOURCE

Although no funds are available specifically for the purchase of assistive technology devices and services, this program can offer services which support and increase access to assistive technology.

COMPLAINT PROCESS

For assistance in resolving a complaint, contact the Client Assistance Program. See Directory: Client Assistance Program (CAP).
CONTACT INFORMATION
For further information, contact one of the Independent Living Centers. See Directory: Centers for Independent Living.

THE INTERAGENCY PROGRAM FOR ASSISTIVE TECHNOLOGY

Since 1993, the Interagency Program for Assistive Technology (IPAT) has been dedicated to supporting the Assistive Technology (AT) needs of all people with disabilities in North Dakota. The vision of this program is to:

“increase access to assistive technology (AT) devices and services for all people in North Dakota, to improve their lives in the areas of work, independent living, learning, community involvement and recreation.”

This goal will be realized through:
- Interagency coordination;
- Public awareness activities;
- Technical assistance and training; and
- Outreach activities to all regions of this rural and sparsely populated state.

IPAT pursues its goal by supporting a variety of activities at local and statewide levels. The program currently provides:
- Technical assistance to systems responsible for the provision of assistive technology in the development and implementation of laws, regulations, and policies governing assistive technology;
- Technical assistance to individuals with disabilities and service providers through regional offices;
- An equipment loan library;
- Advocacy services;
- Coordination of interagency activities supporting AT awareness and building AT resources;
- Training;
- Development and dissemination of AT materials;
- Toll-free AT Help-Line;
- Outreach services through subcontractors;
- Alternative financial loan program; and
- On-going evaluation of consumer satisfaction.

IPAT is North Dakota’s “Tech Act” Program. Every state and six of the territories have a “Tech Act” program, which are funded through the U.S. Department of Education, Office of Special Education and Rehabilitative Services (OSERS), and the National Institute on Disabilities and Rehabilitation Research (NIDRR). These funds are made possible through Title I of the 1998 reauthorization of the Assistive
Technology Act which was first put into place in 1988. IPAT is a program of the North Dakota Department of Human Services, Division of Vocational Rehabilitation.

**ELIGIBILITY**
IPAT provides the above services for all people with disabilities, their families, and/or service providers who reside in North Dakota.

**ASSISTIVE TECHNOLOGY FUNDING SOURCE**
Although no funds are available specifically for the purchase of assistive technology devices and services for individuals, this program can offer services which support and increase access to assistive technology.

**COMPLAINT PROCESS**
For assistance in resolving a complaint, contact the Client Assistance Program. See Directory: **Client Assistance Program (CAP)**.

**CONTACT INFORMATION**
For further information, contact one of the IPAT offices nearest you. See Directory: **Interagency Program for Assistive Technology (IPAT)**.

**AMERICANS WITH DISABILITIES ACT AND EMPLOYMENT**

The Division of Vocational Rehabilitation provides the leadership for the implementation of the American with Disabilities Act (P.L. 101-336) in North Dakota.

Under Title I of the Americans with Disabilities Act, employers may be required to provide reasonable accommodations for qualified workers and potential employees with disabilities. Such accommodations may include purchasing assistive technology devices and services, making equipment modifications, or making the work place accessible.

The employer does have the responsibility, however, if the employer has verified financial hardship in providing assistive technology and other resources, such as tax credits, have been pursued, employees may offer to share the cost. Employees may want to investigate eligibility for benefits through Vocational Rehabilitation and/or other services to assist with the purchase of assistive technology.

Some employers may qualify for Business Expense deductions or Disabled Access Credit, which will offset some of the cost. For more information, employers can obtain the following publications from the Internal Revenue Service (IRS):

- Publication 334- Tax Guide for Small Businesses
- Publication 8826- Disabled Access Credit
If a person believes that assistive technology has not been provided as a reasonable accommodation for employment, or feels they have been discriminated against in any other way, a complaint can be pursued in a variety of ways, depending upon the applicable law. Contact should be made with a Protection & Advocacy advocate or an attorney for assistance in filing such a complaint.

**CONTACT INFORMATION:**
For more information about the Americans with Disabilities Act, contact the ADA State Coordinator for North Dakota. See Directory: *Americans with Disabilities Act (ADA).*

**OTHER FUNDING OPTIONS TO CONSIDER**

In spite of assistive technology’s exemption from Vocational Rehabilitation’s comparable benefits restrictions, it is sometimes favorable for the client to obtain equipment through other programs. The VR counselor may recommend and then assist in accessing these or other assistive funding sources.

**MEDICALLY NECESSARY EQUIPMENT AND SERVICE**
Public or private insurance can be an alternate source of assistive technology funding. For additional information, please refer to the Medicaid and insurance sections of this guide.

**WORK SITE EVALUATIONS/ACCOMMODATIONS**
Depending upon the complexity of the situation, the VR counselor may either perform a work site evaluation or authorize the appropriate allied health professionals or contractors to do so. All such services are available at no cost to the client. If adaptive equipment is required, it is written into the IPE and the client and the counselor pursue the most appropriate and timely purchasing option. An employer, for example, may be legally responsible for purchasing the equipment as a reasonable accommodation under the Title 1 of the Americans with Disabilities Act (ADA).

**WORK INCENTIVES PROGRAMS**
The Social Security Administration has a variety of work incentive options which are available for individuals who receive Social Security benefits and are interested in entering the labor market. Some of these incentives may be used to assist the individual in obtaining assistive technology, which allows them to engage in competitive employment.

Under the Plan for Achieving Self Support (PASS), for example, the individual sets aside funds to purchase services and goods directly related to achieving a specific vocational objective. The Blind Work Expense (BWE) and Impairment Related Work Expense (IRWE) are also available to SSI recipients. A more detailed description of
these programs, including eligibility criteria, appears in the Social Security Section of this guide.

**WORKERS’ COMPENSATION INSURANCE**

Employers are required by law to provide this type of coverage. If a person’s disability is due to a work-related illness or injury, Workers’ Compensation is another possible assistive technology funding source. Find more information on Workers’ Compensation in the Insurance Section of this Guide.
PUBLIC EDUCATION: School-Aged Children

Children with disabilities who need assistive technology devices and services in order to benefit from education are entitled to have access to such devices and services under three laws:

- The Individuals with Disabilities Education Act Amendments of 1997
- Section 504 of the Rehabilitation Act of 1973
- Americans with Disabilities Act of 1990

INDIVIDUALS WITH DISABILITIES EDUCATION ACT AMENDMENTS OF 1997

In accordance with the Individuals with Disabilities Education Act Amendments of 1997 (IDEA ’97), Public Law 105-17, public schools are required to provide assistive technology devices and services to eligible students under IDEA if the student’s Individualized Education Program (IEP) team determines that the student needs assistive technology devices and/or services to receive a free appropriate public education.

Assistive technology devices and services are defined in IDEA as follows:

ASSISTIVE TECHNOLOGY DEVICE
“. . . any item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of individuals with disabilities” [20 U.S.C. Chapter 33, Section 1401 (25)].

ASSISTIVE TECHNOLOGY SERVICE
“. . . any service that directly assists an individual with a disability in the selection, acquisition, or use of an assistive technology device. Such term includes—

A. the evaluation of the assistive technology needs of an individual with a disability, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the individual in the customary environment of the individual;

B. services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices by individuals with disabilities;

C. services consisting of selecting, designing, fitting, customizing, adapting, maintaining, repairing, or replacing assistive technology devices;
D. coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with education and rehabilitation plans and programs;

E. training or technical assistance for an individual with disabilities, or, where appropriate, the family members, guardians, advocates, or authorized representatives of such an individual; and

F. 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 individuals with disabilities.”

ELIGIBILITY
A child with disabilities, under IDEA, is identified as any child with mental retardation, hearing impairments (including deafness), speech or language impairments, visual impairments (including blindness), serious emotional disturbance, orthopedic impairments, autism, traumatic brain injury, other health impairments, specific learning disabilities, or multiple disabilities and who needs special education and related services because of having any of these conditions.

ASSISTIVE TECHNOLOGY FUNDING SOURCE
School districts must pay for a child's assistive technology devices and services if it is determined by the IEP team that they are needed by the child to benefit from the educational program.

According to the IDEA Amendments of 1997, assistive technology devices and services must be considered for each student when developing an Individualized Education Plan. The school district’s obligation for assistive technology reads as follows:

Each public agency shall ensure that assistive technology devices or assistive technology services, or both, are made available to a child with a disability if required as part of the child’s:
   a) Special education,
   b) Related services, or
   c) Supplementary aids and services.

Special Note: School districts, which purchase assistive technology devices for their students, maintain ownership of those devices.

SPECIAL EDUCATION SERVICES
The following six principles provide the foundation for the design of special education services for all eligible children with disabilities and will be helpful to understand in terms of assistive technology:
1. FREE APPROPRIATE PUBLIC EDUCATION (FAPE)
FAPE guarantees the right of all children with disabilities (ages 3-21) to special education and related services provided at public expense with no cost to the parents or guardians.

If determined to be necessary for the student to receive a free appropriate public education, assistive technology devices and services including evaluation, fitting, adapting, training, maintenance, and repair, must be provided by the school at no expense to the family.

2. LEAST RESTRICTIVE ENVIRONMENT (LRE)
LRE requires that all students receive their educational services in the least restrictive environment. Removal from regular education is to occur only when the student cannot be successfully educated in that setting even with supplemental aids and services. Unless the IEP defines other arrangements, each child should be educated in the same school they would attend if they did not have disabilities.

The Least Restrictive Environment mandate has been strengthened by IDEA ’97.
- The IEP team must consider how the student can participate in the general curriculum;
- Students with disabilities cannot be removed from age-appropriate general education classrooms “solely because of needed modifications in the general curriculum”;
- A student cannot be required to demonstrate a certain level of performance in order to be considered for general education class placement;
- Placement decisions must be based on the student’s needs and not on factors such as the availability of services, design of the service delivery system, availability of space, or administrative convenience; and
- The term supplementary aids and services has been defined and includes aids, services, and other supports that are provided in regular education classes or other education-related settings (including extracurricular settings) to enable children with disabilities to be educated with children without disabilities to the maximum extent appropriate.

3. APPROPRIATE EVALUATION
The procedures used to identify a student’s need for assistive technology under IDEA ’97 are the same as those used to determine the need for special education and the development of an Individualized Education Program (IEP).
4. ASSISTIVE TECHNOLOGY CONSIDERATIONS IN THE ASSESSMENT PROCESS

Children with disabilities have the right to assessments in which appropriate accommodations, possibly including assistive technology, are made available when the student’s performance could be significantly impacted. Assistive technology could be a crucial component of the conditions under which assessments occur.

Schools must ensure that tests and evaluation materials are selected and administered to accurately reflect the student’s educational levels or whatever other factors the test purports to measure. As part of the initial planning for a comprehensive assessment for a student with assistive technology needs, the multidisciplinary team members must consider the following technology questions:

- Can the student be evaluated accurately with standard assessment procedures without accommodations?
- If the student uses assistive technology, should it be utilized during the evaluation process? Is the assistive technology functioning appropriately?
- Did the student have an assistive technology evaluation in the past? What were the results?
- Is there a need for an assistive technology evaluation?

Children have the right to an assessment of their technology needs either as part of a comprehensive assessment or as a focused assistive technology assessment. An assistive technology assessment must be tailored to the unique needs of the student.

If the multidisciplinary team decides that an assistive technology evaluation is needed, the team must decide what questions need to be addressed during the assistive technology assessment. These are related to the specific tasks the student needs to be able to perform and what, if any, assistive technology would help. Therefore, prior to conducting the evaluation, a well-developed assessment plan needs to be in place. Listed below are some of the considerations that need to be addressed as part of the assessment plan:

- What tasks do we want the student to do that she/he has difficulty doing or is unable to do?
- What types of assistive technology devices may assist the student in doing the task and remaining in the least restrictive environment?
- Is there a low-technology device that will meet the student’s needs?
- Is the device(s) suited to the student’s educational needs and abilities?
- Is the suitability of the assistive technology device appropriate over time?
- If this is a re-evaluation, will additional information be needed?

When the multidisciplinary team decides, through the assessment planning process, that a student needs an assistive technology evaluation, the team must decide who
will provide the assessment. A school may use its own personnel, contract with an outside source, or use a combination of both to conduct an assistive technology evaluation based upon their skills and experience in the areas of assistive technology.

It is preferable to have the assistive technology evaluation conducted at the school the student currently attends. If the evaluation cannot be conducted on site, it will be necessary for the school to communicate with the parent(s) the details of the evaluation (e.g., date, time, location, transportation) and to ensure that the evaluation can be completed within projected timelines and that all necessary arrangements have been made. If the school and the parent(s) agree that the transportation to the evaluation site will be provided by the parent(s), the school is obliged to provide for the costs of transportation and other related costs, as appropriate.

5. PARENTAL INVOLVEMENT
IDEA '97 has revised the evaluation process, enabling the use of existing data, as appropriate, to make determinations regarding eligibility and the type of educational services needed by the child. The data needs to promote informed decision-making and be relevant to educational programming. It expressly includes collecting and reviewing existing evaluation data, including evaluations and information provided by parents.

Informed parental consent is now required for reevaluations, as well as initial evaluations.

6. INDIVIDUALIZED EDUCATION PROGRAM
The purpose of the Individualized Educational Process is to design an individualized education program to ensure that students with disabilities have adequate educational planning to accommodate their unique instructional needs and that these needs are met in appropriate learning environments. The data gathered from the comprehensive evaluation, including results and recommendations from the assistive technology assessment, must be used in the development of the Individualized Education Program (IEP).

Therefore, if an assistive technology evaluation was conducted as part of the comprehensive evaluation, the IEP team members must consider the results and recommendations of the evaluation when developing the IEP. At least one member of the IEP team must be knowledgeable about what assistive technology exists to help the student with specific tasks and to identify the needed assistive technology services.

IEP Documentation of Assistive Technology Needs
The following are examples of where and how assistive technology needs are documented within the IEP process:
Present Level of Educational Performance
These are statements of the student’s unique pattern of functioning and lay the foundation for succeeding components of the IEP. Statements generated from the integrated written assessment report are incorporated into the present levels of educational performance summary. The results from the assistive technology evaluation report are part of the integrated written assessment report and the present levels of performance.

Goals/Objectives
Goals are related to the unique needs of the student and are achievable within one calendar year. Objectives are subtasks for an annual goal, which form the basis for determining the student’s progress. If assistive technology is needed to enhance a student’s potential to achieve a goal, it should be viewed as a tool in the learning process and not as a goal itself.

Characteristics of Service
Characteristics of service become the basis for establishing the least restrictive environments in which the student will receive special education and related services. This essential analysis incorporates how the assistive technology devices and services enable the student to participate in a particular setting and who will monitor the progress of the objectives relating to assistive technology.

Adaptations of Educational Curriculum and Services
A summary of adaptations of educational curriculum and services will include how assistive technology will be used in the student’s education program. In this section, the IEP team will include items such as a monitoring plan for the assistive technology device and a contingency plan, which would be implemented if the equipment fails to operate.

Special Education and Related Services
The team must specify “what” will be provided, “how much time” the service will entail, and “when and where” it will be provided. If assistive technology devices and services will facilitate the attainment of objectives specified in the student’s IEP, then technical assistance regarding selection, application, and evaluation of identified equipment should be provided. Services required should also be specified. An example of services relating to assistive technology is parent training, in which the parent might need to learn how to use and care for the device.

Least Restrictive Environment
The team will determine when the assistive technology devices and/or services will be provided, and how their use leads to the least restrictive educational setting for the student and access to the general education curriculum.

IEP Notes
In the notes or minutes of the IEP meeting, describe the assistive technology device(s) to be provided, the provider (school/parent/other), the funding source and
ownership of equipment (if funds such as Medicaid or private insurance are to be used, the device belongs to the family), and the anticipated date the device will be provided. If funding sources are being explored, record who is responsible for this activity, and timelines. As appropriate, describe the training to be provided to the parent(s) and professionals involved in implementing the student’s educational program, including timelines.

IMPLEMENTATION
Consideration should be given for day-to-day equipment operation and maintenance, such as who will check to see if the equipment is operating, what repairs are required, or if backup equipment is needed. It is important to identify, in the IEP, a person who will be responsible for monitoring the assistive technology device, as well as its implementation. It may be the special education teacher or another member of the staff who is knowledgeable about the student’s program and the device(s) used. A contingency plan should be in place if equipment fails to operate.

Time should be provided for staff to meet and coordinate the use of the student’s technology in all settings. Additionally, education staff needs to be aware of other sources of information and support to develop their own expertise in the area of assistive technology. Consideration should be given for the training of professionals and para-educator staff regarding use of assistive technology and how to effectively integrate these devices into classroom settings. It is crucial that assistive technology does not become a barrier to the inclusion of a student with a disability into the general education classroom. All IEP team members should continually ask the following questions after the use of an assistive technology device has been initiated:

- Are the assistive technology devices and services that were provided being utilized?
- Are the assistive technology devices and services functioning as expected?
- Are the assistive technology devices supporting the student as expected? If no, why not?
- Who is responsible for each of these actions?
- Who is responsible for monitoring each aspect of the implementation of assistive technology goals and objectives?
- How will student progress on IEP goals be reported to the parents?

ANNUAL REVIEW
IDEA requires that each student’s IEP be reviewed at least annually, and more frequently if requested by any IEP member, including parents. This review should include the evaluation of the effectiveness of the assistive technology that has been implemented and whether any revisions or adjustments need to be made.

Reviews should also occur more frequently if the assistive technology is not operating correctly or if the student is ready to advance to a new technology device or service. A review is particularly important if the student is transitioning to a
different educational environment. Staff members who are unfamiliar with the
devices should be trained and the new setting analyzed to ensure its compatibility
with the assistive technology.

**APPEALS**

Any decision made during the IEP process or at the IEP meeting may be
appealed by the student’s parents. A parent who disagrees with a proposed
IEP, or its implementation, can request a hearing and be represented by an attorney
or other advocate.

The current program remains in place during the appeal. If, for example, last year’s
IEP provided a special computer and the new IEP eliminates it, an appeal
guarantees that the computer is supplied during the course of the appeal.

Mediation is also an option for the parties in dispute. Trained mediators are
available through the North Dakota Department of Public Instruction.

A parent may also file a complaint with the North Dakota Department of Public
Instruction, who is then to initiate an investigation into the matter. This may be
especially important if assistive technology has been identified as a need
somewhere in the IEP, but the school has failed to provide the device and/or service,
as specified.

**REHABILITATION ACT OF 1973**

**SECTION 504**

Section 504 of the Rehabilitation Act of 1973 requires that any agency which
receives federal funding must provide qualified persons with disabilities equal
access to the services, programs, and activities that are offered by that agency. If
an agency receives federal funding, it cannot discriminate against qualified persons
with disabilities in any of its activities, including its employment practices.

**FREE APPROPRIATE PUBLIC EDUCATION UNDER SECTION 504**

Section 504 requires that school districts provide a free appropriate public education
to children with disabilities within their jurisdiction, regardless of the nature or
severity of the student’s disability. An appropriate education under Section 504
means providing regular or special education and related services to meet the
individual educational needs of children with disabilities as adequately as the needs
of children without disabilities are met. Section 504 focuses on guaranteeing equal
access to educational services for students with disabilities. This is a different focus
than the free appropriate public education requirements of the IDEA. To adequately
meet the needs of students with disabilities, Section 504 requires that school
districts provide related and supplementary services to support the student with a
disability.
Section 504 also requires that students with disabilities:

- Receive educational services with students without disabilities to the maximum extent appropriate to the needs of the student with a disability;

- Must be placed in the regular educational environment unless it is demonstrated by the district that the education of the student in a regular educational environment with the use of supplementary aids and services cannot be achieved satisfactorily;

- When placing children with disabilities in a placement other than the regular educational environment, the school district must consider how close the alternate setting is to the student’s home;

- School districts must also ensure that students with disabilities participate in nonacademic and extracurricular activities with students without disabilities to the maximum extent appropriate to the needs of the student with the disability; and

- Nonacademic and extracurricular activities include: meals, recess periods, counseling services, physical recreational activities, special interest groups or clubs, referrals to agencies that provide assistance to persons with disabilities, and employment of students.

**ELIGIBILITY**
Section 504 of the Rehabilitation Act provides broader coverage than IDEA and its definition of a child with disabilities reflects this. Under Section 504, a child has disabilities if they have a physical or mental impairment that substantially limits one or more of their major life activities. These activities include; caring for ones’ self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working, or if they have a record of having an impairment or are regarded as having an impairment. To be eligible under Section 504, a child does not have to need special education and related services.

**ASSISTIVE TECHNOLOGY FUNDING SOURCE**
Although Section 504 of the Rehabilitation Act does not provide funding, students with disabilities are entitled to assistive technology devices and services under Section 504 if the student needs those devices and services to ensure equal access to the public school program. In many cases, Section 504 also requires payment for training, repairs, and maintenance. All costs are the responsibility of the school.

**Special Note:** School districts which purchase assistive technology devices for their students maintain ownership of those devices.

**PROCEDURES FOR OBTAINING ASSISTIVE TECHNOLOGY**
Schools must develop procedures to determine eligibility under Section 504 and to evaluate the needs of children with disabilities not covered by IDEA. Procedures must meet the following requirements:

a) There must be a comprehensive, individualized evaluation of needs, with regular re-evaluations.

b) Decisions must be made by a group of people, including the parents, who are knowledgeable about the child, the evaluation information, and the placement options. In North Dakota, schools use “building level support teams” or “teacher assistance teams” to address this requirement.

c) The student’s needs and services to be provided must be identified in writing.

Special Note: Parents who disagree have due process rights, including the right to a hearing, but do not have the right to an independent evaluation at school expense or to continued services pending an appeal.

**APPEALS**
Each school is required to have a Section 504 Coordinator who is responsible for receiving complaints of discrimination. On the federal level, the Office of Civil Rights is also responsible for receiving and responding to complaints of discrimination under Section 504 of the Rehabilitation Act.

**CONTACT INFORMATION**
For further information, contact North Dakota’s Protection & Advocacy Project. See Directory: Protection & Advocacy Project.

**AMERICANS WITH DISABILITIES ACT AND EDUCATION**
The Americans with Disabilities Act (ADA) of 1990 is a nondiscrimination statute. Title II of the ADA mandates that public entities must provide program access in an integrated setting, unless separate programs are necessary to ensure equal benefits or services. Schools are required to make their programs and services accessible to students with disabilities. They may employ assistive technology or various other means to make the necessary accommodations, but there are limitations. Although public entities must ensure that individuals with disabilities receive the same benefits and services offered to others without disabilities, they do not have to take actions or make accommodations that would cause:

- Fundamental alteration of the nature of the program or activity, or
- Undue financial or administrative burdens.

The ADA, unlike Section 504, does not require that agencies receive federal funding in order to fall within the ADA’s coverage.
ELIGIBILITY
Under the ADA, an individual is considered to have a “disability” if he/she has:

…a physical or mental impairment that substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment.

Persons discriminated against because they have a known association or relationship with an individual with a disability are also protected under the ADA.

SERVICES
In North Dakota, the Division of Vocational Rehabilitation provides the leadership for the implementation of the Americans with Disabilities Act. Some of the available services include:

• Materials in various formats, such as Braille, large print, audiocassette, etc.;
• Technical assistance;
• Resource information on accessibility, state and local government services and programs, telecommunications, and employment; and
• Information on how to file a claim.

PRIVATE SCHOOLS
Title III of the ADA applies to privately operated public accommodations, including places of education and elementary and secondary private schools. Private schools, therefore, are prohibited from discriminating against qualified students with disabilities. Private schools are not required by the ADA to provide students with disabilities a free appropriate education, but they are required to provide assistive technology services when needed to ensure that students with disabilities are not denied services, excluded from the school, or treated differently. Private schools that are operated by religious entities are not covered by the ADA.

ASSISTIVE TECHNOLOGY FUNDING SOURCE
A student who is covered under the ADA may receive assistive technology as a reasonable accommodation if needed in order to participate in education equally with other students. Eligibility for special education services under IDEA is not required for a student to receive the assistive technology devices and/or services needed to overcome functional limitations. A specially designed desk, screen enlargement software, or an oversized computer monitor may be such a reasonable accommodation.

School districts also are required to provide auxiliary aids and services that would be needed to ensure effective communication for persons with disabilities in using the school district’s services. Examples include: telephone handset amplifiers, assistive listening devices and systems, telephones compatible with hearing aids, closed captioned decoders, taped texts, audio recordings, Brailled materials, and large print materials.
Special Note: School districts, which purchase assistive technology devices for their students, maintain ownership of those devices.

COMPLAINT PROCESS
If you feel that the school is not providing equal access to programs and services, contact the Department of Public Instruction and ask for the ADA Coordinator for Education. See Directory: Education-Department of Public Instruction. If your complaint is not resolved to your satisfaction, a complaint may be filed with the Office for Civil Rights (OCR). See Directory: Office for Civil Rights (OCR).

CONTACT INFORMATION
For more information, contact the Americans with Disabilities Act. See Directory: Americans with Disabilities Act (ADA).

INDIVIDUALS WITH DISABILITIES EDUCATION ACT
(Children Age Birth – Three)

Part C of the Individuals with Disabilities Education Act (IDEA), as amended, was formerly called Part H. This is the federal law that provides funding for early intervention services for eligible children from birth to age three who are experiencing, or are at risk of experiencing, developmental delays. In North Dakota, eligibility is extended to include those who are at risk of having substantial developmental delays if early intervention services are not provided. The Part C program is called Early Intervention Services and, in North Dakota, is coordinated by the Developmental Disabilities Division of the Department of Human Services.

ELIGIBILITY
Part C serves infants and toddlers who are experiencing developmental delays in cognitive, physical, communication, or social or emotional development, or in self-help skills (adaptive development), or who have a diagnosed physical or mental condition which has a high probability of resulting in developmental delay.

Eligibility Process
A comprehensive child find system is conducted throughout North Dakota by local interagency coordinating networks. Child Find must include local awareness, referral, and screening procedures. A screening process determines initial eligibility.

If a child is found to potentially need services, he/she is referred to a multi-disciplinary team for assessment of the following developmental areas: cognitive development; physical development, including vision and hearing; communication development; social/emotional development; and adaptive development. Depending upon the extent of the child’s delays, the team determines eligibility for services.
Although most infants and toddlers will not have had access to assistive technology devices and services before their evaluation for Part C eligibility, those who have and use assistive technology within routine daily activities must have those devices available and incorporated into evaluation activities.

**ASSISTIVE TECHNOLOGY FUNDING SOURCE**
Children enrolled in the Part C program may receive assistive technology devices and services as Early Intervention Services. Assistive technology is listed as a mandatory early intervention service. Although Part C is a payer of last resort for early intervention services, including assistive technology devices and services, Part C does pay for assistive technology if there is no other payer.

Part C also serves as a monitoring and coordination program which can be particularly useful in assisting parents and professionals in accessing adequate and appropriate funding for assistive technology.

**ASSISTIVE TECHNOLOGY FOR INFANTS AND TODDLERS**
Assistive technology, ranging from simple to complex devices, is used to facilitate an array of developmental levels and skills for infants and toddlers. The primary goal for assistive technology use with very young children is to provide access to social and educational activities and to increase their opportunities to interact with family members and other children. Discovering ways in which assistive technology can be used meaningfully in play and daily family routines is critical to the success of the technology’s implementation.

Types of assistive technology typically funded include: environmental controls, independent living aids, computers, computer adaptations, computer software, ergonomic adaptations, switches, educational aids, mobility aids, prosthetics & orthotics, seating & positioning aids, therapeutic aids, transportation aids, architectural adaptations, communication devices, sensory aids, and recreation aids. In other words, any assistive technology listed in a child’s Individualized Family Service Plan (IFSP) could be provided.

**INDIVIDUALIZED FAMILY SERVICE PLAN**
The Individualized Family Service Plan (IFSP) is the document that summarizes the child’s present levels of development, identifies the outcomes expected, and the specific early intervention services needed to achieve the stated outcomes. Every child who is eligible for and receives Part C services must have an IFSP developed with the family and IFSP team members.

Children enrolled in the Part C program may receive assistive technology devices and services if they are specified on the IFSP.

**TRANSITIONING TO THE SCHOOL SETTING**
A transition plan must be developed to support and prepare a child reaching the age of three years and the family, at which time he/she is no longer eligible for early
intervention services. With parental consent, a meeting must be held at least 90 days prior to the child’s third birthday, the time at which he/she may be eligible for preschool special education services.

It is important to define mechanisms to ensure the uninterrupted provision of assistive technology devices and services for the child during this transition planning process.

**APPEALS**

As with other parts of IDEA, there are procedural safeguards for children and families’ rights concerning evaluations, the development, and implementation of the IFSP, and the right to appeal decisions of the IFSP team. The North Dakota Protection and Advocacy Project is available to provide assistance.

**CONTACT INFORMATION**

For further information, contact the North Dakota Office of Developmental Disabilities. See Directory: *Developmental Disabilities.*
US DEPARTMENT OF EDUCATION: Letters of
Clarification on Assistive Technology

23 IDELR 565
2 ECLPR ¶ 169

Fisher, Letter to (IEEs/ Assistive Technology Devices)
Office of Special Education Programs

Digest of Inquiry
[Date Not Provided]

- Must a local school system pay for independent assistive technology evaluations, as they must for independent educational evaluations?

Digest of Response
December 4, 1995

Right to IEE Includes Evaluation of Needs for Assistive Technology
A public agency must evaluate a student in all areas of suspected disability, including, if warranted, whether a student's functional capabilities require the use of assistive technology devices or services. Likewise, a parent's right to seek an independent educational evaluation (IEE) includes an assessment that will enable an IEP team to determine a student's needs for assistive technology. The right to an IEE extends to situations where the school neglects to evaluate the student for assistive technology needs as well as instances where the parent disagrees with the school's evaluation in that area. Alternatively, a parent can also request that the school conduct a reevaluation of the student's need for assistive technology.

22 IDELR 888

Naon, Letter to (Assistive Technology Devices)
Office of Special Education Programs

Digest of Inquiry
March 6, 1995

- What obligation do educational agencies have to provide assistive technology?
- Is there a list of types of assistive technologies and equipment for each type of disability?

Digest of Response
January 26, 1995

District Must Provide Assistive Technology/Devices Necessary for FAPE
34 CFR 300.5 and 34 CRF 300.6 of the Part B regulations require each public agency to ensure that a student with a disability receives the assistive technology devices and services which are necessary for FAPE. The determination as to
whether the assistive technology devices and services are necessary for FAPE is to be made by the student's IEP team, and the relationship that must exist is between the student's educational needs and the device or service.

Need for Assistive Technology Devices/Services Must Be Based Upon Individual
There are no predetermined listings of assistive technology devices and or services, which relate to particular types of disabilities. Rather, the need for a particular device or service must be based upon the unique needs of each individual student.

22 IDELR 629
2 ECLPR ¶ 100

Bachus, Letter to (Eyeglasses/Hearing Aids)

Digest of Inquiry
April 12, 1994

- Is a public agency required to provide eyeglasses to a visually impaired student whose parents cannot afford them? If so, who is responsible for the evaluation expense to determine the need for glasses, and for a hearing aid?
- Is a public agency responsible for providing eyeglasses to a student with a disability other than a vision impairment?

Digest of Response
January 13, 1995

LEA Must Provide Eyeglasses if They Are Necessary for FAPE and Included in IEP
If a student with a vision impairment requires eyeglasses regardless of whether he or she was attending school, then a public agency will NOT be required to provide them to the student. However, if the public agency determines that the child with a disability requires eyeglasses in order to receive FAPE and the child's IEP specifies that the child needs eyeglasses, then the public agency must provide the eyeglasses at no cost to the parents and could seek funds from outside of the agency to do so. When evaluating a student, the public agency must assess in all areas related to suspected disability, including if appropriate, vision, and hearing. Thus, if the student is suspected to have visual or hearing deficits, then the public agency is responsible for the costs of the vision and hearing assessments.

For Students with Disabilities Other than Visual Impairment, IEP Team Must Determine Whether Eyeglasses Are Necessary for FAPE
The determination as to a public agency's duty to provide eyeglasses to a student with a disability other than a visual impairment is to be made by the student's IEP team in light of a consideration of whether the eyeglasses are necessary in order to receive FAPE.
Anonymous, Letter to (Assistive Technology)

Digest of Inquiry
June 9, 1994

- Is a school district responsible for an assistive technology device, purchased by the parent, if that device is utilized by the student in completion of his/her IEP goals and therefore his/her academic work?

Digest of Response
August 9, 1994

Although Not Mandatory, Assuming Liability for Family-Owned Assistive Technology Devices is Reasonable

Although a district must provide assistive technology devices that are necessary for FAPE at no cost to parents, federal law does not specify whether a district must assume responsibility for such a device when it is purchased by the parent and used by the district to implement the student's IEP, either in school or at home. However, it is reasonable for states to require districts to assume such liability, since the district is responsible for providing services and devices specified in a student's IEP, and without the use of the family-owned device, the public agency would be required to provide and maintain a needed device. However, there may be some instances when assuming such liability would create a greater responsibility for the district than exists under federal law.

Seiler, Letter to (Assistive Devices)
Office of Special Education Programs

Digest of Inquiry
April 21, 1993

- If a student needs a hearing aid and the device is put on the student's IEP, does the IDEA require the school district to purchase the device?

Digest of Response
November 19, 1993

Hearing Aid Must be Provided at No Cost When Specified in IEP

A hearing aid is considered a covered device under the definition of “assistive technology device.” Thus, where a district has determined that a child with a disability requires a hearing aid in order to receive FAPE and the child's IEP specifies that the child needs a hearing aid, the district is responsible for providing the hearing aid at no cost to the child and his or her parents in accordance with 34 CFR 300.308.
Cohen, Letter to (Assistive Technology)

Digest of Inquiry
April 6, 1992

- How can school districts be expected to provide potentially expensive assistive technology services and devices with limited available resources?

Digest of Response
July 9, 1992

Alternate Funding Sources Are Available for Assistive Technology
State and local educational agencies (SEAs and LEAs) may access alternative funding sources such as Medicaid, Maternal and Child Health (MCH), and private insurance proceeds in order to defray the costs of providing assistive technology services and devices to children with disabilities. However, pursuant to 34 CFR 300.601, the use of alternative sources of public funding may not result in a reduction of the medical or other assistance available to children with disabilities or in an alteration of their eligibility under the Medicaid or MCH programs. Furthermore, any use of private insurance proceeds to provide assistive technology services or devices must comply with the Notice of Interpretation on the Use of Insurance Proceeds and must not pose a realistic threat of financial loss to parents of children with disabilities.

Anonymous, Letter to (Assistive Technology)

Digest of Inquiry
October 18, 1991

- Under what circumstances must a local school district allow a student with a hearing impairment to use an FM auditory training system as an assistive technology device?

Digest of Response
April 6, 1992

Use of FM Training System Should Be Discussed During IEP Process
If a student with a hearing impairment has a current IEP, but the IEP does not discuss the use of an FM auditory training system, then the parent may request that an IEP meeting be convened to consider the use of such a system. On the other hand, if the student does not have a current IEP, the parent may request an evaluation, and, if a disability is identified, an IEP must be developed, at which time the use of an FM system can be discussed. In either case, if the parent believes that the student is entitled to, but is not receiving FAPE due to the denial of an FM system, then a request can be made to the school district to conduct an impartial due process hearing, or a complaint can be filed with the state educational agency.
Anonymous, Letter to (Assistive Technology)
Office of Special Education Programs

Digest of Inquiry
[Date Not Provided]

- Is a school district responsible to provide assistive technology devices for home use?
- May a school board overrule a determination by an IEP team that a child with a disability needs access to an assistive technology device at home?
- What is the time limit on implementation of an IEP?

Digest of Response
November 27, 1991

Assistive Technology Devices May Be Required for Home Use
If an IEP team determines that a child with a disability needs access to an assistive technology device at home as a matter of FAPE, then the school district must provide the device for home use in order to implement the child's IEP.

School Board May Not Change IEP Team's Determination
Under Part B, a school board has no authority to unilaterally change any statement of special education or related services contained in an IEP, including a statement of a child's need to have access to an assistive technology device at home. Without reconvening the IEP team, the school board may not change the IEP, and the school district is obligated to implement the IEP requirements, regardless of the school board's objections.

IEPs Must Generally Be Implemented Immediately
Under Reg. 300.342(b), an IEP must be in effect before the provision of special education or related services and must be implemented as soon as possible following the conclusion of the IEP meeting(s). In accordance with Appendix C to the Part 300 regulations, an IEP should generally be implemented without delay after being finalized, although a reasonable delay may be permissible in limited circumstances.

Goodman, Letter to (Assistive Technology)

Digest of Inquiry
[Date Not Provided]

- Must a school district determine the need for "assistive technology" on a case-by-case basis for eligible children with handicaps?
"Assistive Technology" Provided on Case-by-Case Basis
While neither EHA-B nor its implementing regulations define "assistive technology," such assistance might qualify as special education, a related service, or a supplementary aid or service, in accordance with the definitions supplied by the Technology-Related Assistance for Individuals with Disabilities Act. If a type of "assistive technology" is covered by EHA-B, then the determination of a child's need for such assistance must be made on a case-by-case basis in connection with the development of the child's IEP.
MEDICAID

Medical Assistance or Medicaid is a program funded jointly by federal and state governments and administered by states. It provides funding for medical care, rehabilitation, and other services for eligible individuals whose income and resources are insufficient to meet the costs of necessary medical services.

Provided broad federal guidelines, each state decides its own eligibility requirements, the types and range of services, the payment level for services, and administrative and operating procedures. States are not required to provide a Medicaid program, although North Dakota does.

The federal law and regulations provide a general framework stating, for example, that the primary goal of Medicaid is to give medical assistance to persons in need and to furnish them with rehabilitation and other services to help them “attain or retain capability for independence or self-care.” “Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.”

MANDATED SERVICES

Although states may limit the amount, duration, and scope of mandated services, adequate care must be provided. Federal law requires states to provide the following mandatory services, without charge, to Medicaid beneficiaries;

- Inpatient hospital services,
- Outpatient hospital services,
- Rural health clinic services,
- Laboratory and X-ray services,
- Skilled nursing facility (skilled nursing home),
- Physician services,
- Early, periodic screening, diagnosis, and treatment (EPSDT) services for people under age 21,
- Family planning services,
- Dentist surgical services, and
- Nurse midwife services.

In addition, states must:

- Make arrangements to ensure that beneficiaries can get to and from medical services they need;
- Must allow beneficiaries free choice among qualified care providers; and
- Must provide beneficiaries access to health services statewide.
OPTIONAL SERVICES

Each state decides upon optional services it includes in its beneficiary coverage. The state of North Dakota provides coverage for the following optional services: podiatrist, optometrist, chiropractic, psychologist, private duty nursing, clinic, and dental services; physical therapy, occupational therapy, speech/language/hearing services, prescribed drugs, dentures, prosthetic devices, eyeglasses; diagnostic, screening, preventive, rehabilitative, ICF/MR services; inpatient psychiatric over 65 and under 21 years of age, emergency services, case management services, and hospice.

ELIGIBILITY

Medicaid eligibility is determined at local county social service offices. Eligibility categories include the following:

- Persons who have applied for and are receiving financial assistance under the Aid to Families with Dependent Children (AFDC);
- Persons eligible for federal Supplemental Security Income (SSI) are usually eligible;
- Persons with low income who are age 65 or over, who are individuals with disabilities, or are individuals with blindness;
- Families with children and low income in which the parent has died, is incapacitated, or is absent;
- Persons over age 65 with low income and assets who are receiving treatment at the State Hospital in Jamestown, ND;
- Persons under the age of 21 and residing in licensed foster care homes who do not exceed assets and income standards established by the state;
- Adoptive children under age 21 may be eligible under the state’s “subsidized adoption law”;
- Persons under the age of 21 who, under state standards, do not have sufficient income and assets to meet medical expenses;
- Pregnant women and infants to age 6 who, under state standards, do not have sufficient income to meet medical expenses;
- Children age 6 – 18 who, under state standards based on the poverty level, do not have sufficient income to meet medical expenses;
• Qualified Medicare Beneficiaries (QMB), aged, with blindness, with disabilities, who are entitled to Medicare Part A, who meet asset and poverty level standards may be eligible for coverage of the Medicare premium, co-insurance, and deductibles;

• Qualified Disabled and Working Individual (QDWI) persons entitled to enroll in Medicare Part A, who meet asset and poverty level standards and who are not eligible for Medicaid under any other provisions may be eligible for Medicare Part A premium coverage; and

• Special Low Income Medicare Beneficiaries (SLMB), aged persons, persons with blindness, persons with disabilities who are entitled to enroll in Medicare Part A, who meet asset and poverty level standards may be eligible for Medicare Part B premium coverage.

APPLICATION PROCESS
Applications are available at the local county social service offices.

Special Note: Although other programs often do not provide assistance to address the results of issues such as suicide attempts and alcohol/drug abuse, Medicaid does.

ASSISTIVE TECHNOLOGY FUNDING SOURCE
Assistive technology devices and services have potential for Medicaid funding for Medicaid beneficiaries under several primary mandatory and optional areas currently covered. Assistive technology devices and services very often fall under one or more of the following areas:

• **Home Health Care Services:** This includes, among many other services, medical supplies, equipment, and appliances recommended by a physician and suitable for use in the home.

• **Early Periodic Screening Diagnostic Treatment Services (EPSDT):** This mandatory service is available to children from birth through age 21, and includes coverage for all mandatory and optional services, whether or not they are covered in the state’s Medicaid plan.

• **Durable Medical Equipment (DME):** The federal government usually defines DME as equipment which a) can withstand repeated use, b) is primarily and customarily used to serve a medical purpose, c) generally is not useful to a person in the absence of an illness or injury, and d) is appropriate for use in the home.

• **Physical, Occupational, & Speech/Language/Hearing Therapy:** For the purposes of assistive technology funding, the key phrase in the definitions of these services is “any necessary supplies and equipment,” thus including
equipment and devices that are recommended within the professional expertise and licensure of the therapists.

- **Prosthetic Devices:** Devices whose purpose is to replace a missing portion of the body, to prevent or correct physical deformity or malfunction, or to support a weak or deformed part of the body. For example, an augmentative communication device could be considered a prosthetic device to replace a weak or deformed part of the body.

- **Diagnostic, Screening, & Preventive Services:** Medical procedures or supplies/standardized tests recommended by the patient’s physician to screen/identify/prevent illness, injury, health deviation, disability, or their progression.

- **Rehabilitative Services:** Any medical remedial items or services prescribed by the patient’s physician or licensed practitioner for the purpose of maximum reduction of physical or mental disability and restoration to the patient’s best possible functional level.

- **Private Duty Nursing:** Nursing services provided under the direction of the physician to a patient in the patient’s own home or extended care facility.

**OBTAINING ASSISTIVE TECHNOLOGY DEVICES AND SERVICES**

Medicaid is a third party payment program. This means that payments are made to second parties, such as equipment suppliers, orthotists, prosthetists, and other providers rather than as a reimbursement to the beneficiaries.

When an individual has been determined to be Medicaid eligible, and appropriate health care professionals have completed a thorough evaluation/assessment of his/her needs, the following process is followed to obtain Medicaid funding:

1) The beneficiary and/or service provider obtains a **physician’s prescription or order** for the equipment from their doctor and a **report of identified needs and recommendations** is completed by the appropriate professionals.

2) The beneficiary and/or service provider provides the prescription and report to the equipment supplier who must be **enrolled as a North Dakota Medicaid provider**.

3) The supplier completes other necessary information (Part II of the “Request for Prior Authorization Form”), including cost and description of equipment. The supplier also sends the Request for Authorization Form to the physician. The physician completes Part I of the form and returns it to the supplier.

4) The equipment supplier submits the Request for Prior Authorization Form, the physician’s prescription, and the report of identified needs and recommendations to Medicaid for a pre-authorization or prior approval number, which authorizes billing.
5) The Medicaid office reviews the information and either approves or denies payment authorization.

6) If approved, the Medicaid office notifies the equipment supplier of its decision and the equipment supplier processes the equipment order.

7) If denied, the Medicaid office notifies the supplier and the beneficiary of its decision. The beneficiary, supplier, or physician may request an informal reconsideration or may initiate a formal appeal of the decision.

8) In an informal reconsideration, the beneficiary may want to contact the supplier and ask for the reasons Medicaid indicated the request was denied. Identified corrections or additions can be made and the supplier can re-submit the request.

9) A formal appeal challenging the denial can be initiated through the county social service office or the Department of Human Services.

Prior Approval
North Dakota requires prior approval for purchases or repairs costing $200 or more. For supplies, prior approval is required if the cost is $200/month or more for any individual supply. For rentals, prior approval is required when the cost will be $200 or more for a year’s time. Requests for prior approval or prior authorization must contain the following information:

- **Request for Prior Authorization Form (Parts I and II):** Equipment providers will have this form.

- **Report(s) of identified needs and recommendations:** These include the general professional experience of evaluator(s), their experience related to assistive technology, a description of the evaluation process, the evaluation results, and the technology selection process.

- **Physician’s prescription or order:** The device(s) may be ordered specifically by a physician. Although Medicaid will only purchase equipment if it is prescribed by a physician, it is important that the doctor rely on the patient and/or family members, the professional(s) recommending the equipment (e.g., therapists, rehab engineers), and DME providers to supply crucial information regarding the technology’s features and benefits.

- **North Dakota Medicaid Provider Number:** To receive payments from Medicaid, each provider must have a “provider number” from Medicaid identifying them as an enrolled Medicaid provider or vendor.

- **Justification for Device:** An explanation of the medical need for the device must be provided, including a description of the technology selected, the projected benefits (i.e., to prevent the onset of specific secondary impairments, decrease depression), and its cost-effectiveness.
Medical Necessity Justification
The first and most important step in developing an effective medical justification for assistive technology/durable medical equipment is the completion of a thorough evaluation and assessment of the person’s needs by a qualified professional(s).

Once a person’s needs have been identified, the appropriate device or device system can be selected. Trial use of this equipment is highly beneficial to appropriate device selection and funding justification. Whether or not Medicaid covers a specific device depends upon the options the State agency has chosen to offer and the eligibility of the person for Medicaid services.

When providing medical justification for an assistive technology device or service, several general principles should be understood:

- The medical purpose of the device is NOT merely to obtain medical treatment for some other impairment. Rather, the purpose of the device is to restore the functional ability of the MEDICAL CONDITION.

  How the individual uses the device, with whom, when, and where, are lifestyle choices over which Medicaid has no control.

- A device which is constructed in such a way it has uses for people without disabilities (such as a computer or a remote control) provides the necessary and specific treatment regardless of whether or not others have uses for it.

- The cause of the beneficiary’s impairment or disability (e.g., congenital, developmental, acquired) or the beneficiary’s age at the onset of the impairment or disability is not relevant considerations in the determination of medical need.

- The unavailability of a device, component, or accessory for rental does not serve as a basis for denying a prior approval request for that item.

- The unavailability of a warranty for a device, component, or accessory does not serve as a basis for denying a prior approval request for that item.

Special Notes:
- Providers bill Medicaid directly and consumers are not responsible for a copayment.
- Devices purchased by Medicaid belong to the consumer.
- Medicaid is a payer of last resort for assistive technology. If consumers have other medical insurance available, it must be used first.
- Schools must obtain permission form parents to obtain a child’s Medicaid or “Access” number to pursue funding for devices for that child.
**APPEALS**

If an applicant’s request for Medicaid is denied, is not acted upon in a timely manner, or if he/she is not satisfied with the county social service board action affecting the receipt of Medicaid, or by policy as it affects his/her particular situation, he/she may request a fair hearing before an appeals referee representing the North Dakota Department of Human Services. Requests may be made through the local county social service board office.

The Interagency Program for Assistive Technology (IPAT) and the North Dakota Protection & Advocacy Project are available to provide assistance in the appeals process.

**CONTACT INFORMATION**

Medicaid of North Dakota is located within the North Dakota Department of Human Services. Additional program information may be obtained by contacting a local county social service office. Phone numbers and addresses of each can be found in the County Government section of local telephone directories.

The Program Administrator of the Medical Services Division, North Dakota Department of Human Services, can also provide additional information. See Directory: Medicaid of North Dakota.

**HOME & COMMUNITY BASED SERVICES**

Medicaid, through Home and Community Based Services (HCBS) waivers, provides another potential avenue for the provision of assistive technology devices and services indirectly. A Home and Community Based Services Waiver is an agreement between the US Health Care Administration (HCFA) and the state Medicaid agency. The 1915 (c) waiver provides the eligible individual a choice between institutional care and living in the community.

In 1981, the federal government recognized that the Medicaid Program had a bias toward funding institutional care, such as nursing homes. Authority for HCFA to approve the HCBS waivers was developed as a means to counter that bias, with the stipulation that the cost of community supports be less than the cost of care to individuals who need an institutional level of care. The waiver is intended to provide payment for needed services, which would not otherwise be covered under the state Medicaid Program. The Aging Services Division of the North Dakota Department of Human Services manages the Traumatic Brain Injury and Aged and Disabled HCBS waivers in this state. The Developmental Disabilities Division manages the Developmental Disabilities HCBS waiver here.
HCBS FOR INDIVIDUALS WITH TRAUMATIC BRAIN INJURY
This waiver was designed to meet otherwise unmet needs of qualifying people with traumatic brain injury (TBI) in North Dakota. These unmet needs could include assistive technology devices and services.

ELIGIBILITY
Eligible individuals must be Medicaid recipients and must also meet the following requirements:

- Must have a diagnosis, which is not congenital or degenerative, of traumatic brain injury or acquired brain injury (e.g., anoxia, infections, CVA, aneurysms, tumors which are not expected to result in death, toxic chemical reactions) resulting in significant emotional, behavioral, or cognitive impairments, and
- Must have been screened at nursing facility level-of-care, and
- Must be between the ages of 18 and through 64 years of age and not served under an Individualized Education Plan (IEP), and
- Must be disabled as determined by Social Security disability criteria, and
- Must be capable of directing his/her own care as determined by the interdisciplinary ICP team, or have a (legally) responsible party to act in the recipient’s behalf, and
- Must have had a neuro-psychological evaluation.

HCBS FOR AGED AND DISABLED
Eligibility and available services for aged and (physically) disabled fall into three categories, each having their own specific funding source. All, however, must:

- Be capable of directing their own care or have a legally responsible party act in their behalf.
- Not be living in an institution, dormitory, or congregate housing (An exception provides for eligible recipients of the Expanded Service Payments for Elderly and Disabled Program to receive services in “congregate housing”).
- Need for service is not due to mental illness or mental retardation.
- Have need within the scope of covered services.

Medicaid Waiver (Aged and Disabled)
These funds are provided through a federal and state match. Services include: homemaker, chore, respite, HCBS case management, personal care service, adult foster care, adult day care, non-medical transportation, family/caregiver training, environmental modifications, special equipment, and Emergency Response System.

ELIGIBILITY
These services are available to individuals who:
• are age 65 or older or, if under 65,
• are determined to be disabled under Social Security Administration criteria, and
• are screened in need of nursing facility care, and
• whose spouse or parent (if minor child) is not the provider.

Service Payments for Elderly and Disabled (SPED) Program
SPED program services are provided through a 95% state general funds and 5% county match and include: homemaker, chore, respite, HCBS case management, personal care service, limited environmental modification, Emergency Response System, adult family foster care, adult day care, non-medical transportation, and family home care.

ELIGIBILITY
Financial eligibility includes having resources less than $50,000 and a sliding fee scale is applied based on current income. To be included in the SPED program pool, individuals must meet the following criteria:
• Must be impaired in 4 Activities of Daily Living (ADL), OR in 5 Instrumental Activities of Daily Living (IADL), with total of 8 points (or 6 points if living alone);
• Impairments must have lasted or are expected to last 3 months or more; or
• If under the age of 18, screened for nursing care facility;
• Ineligible for Waiver.

Expanded SPED Program
Services under this program include: homemaker, chore, HCBS case management, personal care service, adult family foster care, family home care, non-medical transportation, Emergency Response System, respite care, and adaptive assessment.

ELIGIBILITY
Eligibility for the Expanded SPED program includes:
• Medical Assistance (Recipient/Eligible),
• Not severely impaired in ADLs: toileting, transferring, eating,
• Impaired in 3 of 4 ADLs: meal preparation, doing housework, doing laundry, taking meds, or
• Needs supervision or structured environment.

Definitions of In-home Services
In-home services must be provided in the client’s home; community-based care is limited to that setting. Of particular interest in terms of assistive technology devices and services are:
• **Environmental Modification:** Modify home to increase client’s independence. This could include widening a doorway to allow wheelchair access.

• **Specialized Equipment:** Provision of special equipment to lessen the need for human help. This could include environmental control systems, vehicle modifications, and a range of adaptive devices.

• **Training Family Member:** Improve skills of non-paid primary caregiver family member.

• **Adaptive Assessment:** Determines what equipment will enhance client’s personal functional ability.

• **Respite Care:** Relief of primary full-time caregiver.

• **Personal Care Service:** Daily personal care, e.g., bathe, dress, transfer, toilet, supervise.

**Definitions of other services provided include:**

• **HCBS Case Management:** Assessment, care planning, provider selection, monitor services, make referrals.

• **Adult Family Foster Care:** Safe supervised family living environment, providing 24-hour care or supervision, licensed by the state.

• **Homemaker Service:** “Care” of environment, e.g., cleaning home, laundry; meal preparation.

• **Chore Service:** Snow removal, minor home repairs, install safety bars.

• **Non-Medical Transportation:** Transporting and/or escorting client to essential needs, e.g., grocery, utility company, Social Security office.

• **Family Home Care:** Client and family member meet degree of relationship as defined by state law and reside in same home on a 24-hour basis.

• **Adult Day Care:** At least three hours of care in a group setting per day.

**APPLICATION INFORMATION**

Application for services under the Aged & Disabled Waiver, TBI Waiver, SPED Program, and Expanded SPED Program is made with an HCBS case manager or social worker at the local county social service office in the county in which the applicant lives.
DEVELOPMENTAL DISABILITIES WAIVER

ELIGIBILITY

Services covered under this waiver can be provided to those individuals who:

• Have developmental disabilities,
• Are Medicaid eligible,
• And who require Intermediate Care Facilities for the Mentally Retarded (ICFMR) level of care.

Waivered services cannot duplicate those already provided by Medicaid.

APPLICATION INFORMATION

Application for services under the DD Waiver is made with Developmental Disabilities case managers, who are located in the human service centers.

ASSISTIVE TECHNOLOGY FUNDING SOURCE

The Aged & Disabled Waiver, TBI Waiver, SPED Program, Expanded SPED Program, and the DD Waiver are not specific assistive technology-funding sources at this time. Individuals involved in the Independent Supported Living Programs (ISLA), however, may be provided financial assistance to help pay for technology that reduces dependence upon paid supports.

APPEALS

If an applicant’s request for Medicaid is denied, is not acted upon in a timely manner, or if he/she is not satisfied with the county social service board action affecting the receipt of Medicaid, or by policy as it affects his/her particular situation, he/she may request a fair hearing before an appeals referee. Requests may be made through the local county social service board office.

The Interagency Program for Assistive Technology (IPAT) and the North Dakota Protection & Advocacy Project are available to provide assistance in the appeals process.

CONTACT INFORMATION

For further information regarding HCBS waivers, contact your local county Social Services office. Phone numbers and addresses of each can be found in the County Government section of local telephone directories. Questions? Call the Senior Info-Line. See Directory: Senior Info-Line.

For more information regarding the DD waiver, contact regional Developmental Disabilities Case Management staff at one of the eight regional Human Service Centers. See Directory: Human Service Center Offices, Regional.
MEDICARE

In 1965, the Social Security Act was amended to establish Medicare, a health insurance program for the aged. Later amendments extended the health care coverage to those who were under 65 and had disabilities, and to people with end-stage kidney disease. Medicare is often confused with another health care program called Medicaid - also known as Title 19 - a statewide program, which provides medical care and services to needy individuals. Medicare is a nationwide program that is the same throughout the nation, whereas Medicaid may vary state to state and is financed with state monies plus federal matching funds.

Although this section of the Guide contains policy, interpretations, and helpful hints for the readers, the individual Medicare determinations in each case are controlling.

ELIGIBILITY

All Americans and their dependents earn eligibility for Medicare during their working years when they and their employers contribute to the Medicare Trust Fund through Social Security taxes.

Those eligible for Medicare include:

- People age 65 and over;
- Individuals under 65 years of age and disabled under Social Security for 24 months; or
- People with end-stage kidney disease.

COVERAGE

Medicare coverage has two parts:

Part A (Hospital Insurance)

- Care in hospitals, skilled nursing facilities, hospice, and some home health care.
- Most people do not have to pay a premium because they paid Medicare taxes while they (or a spouse) were working.
- Out-of-pocket costs for hospital and nursing home stays are a determined amount per day, dependent upon the amount of days one has been admitted.
- For hospice care, a small copayment for outpatient prescription drugs as well as small copayment for inpatient respite care is required.
- There is no additional cost for home health care services. However, one is responsible for the first 20% of the Medicare-approved amount for durable medical equipment.
- Assistive technology devices and services may be funded if they fall within covered services under Home Health Care, which includes: physical therapy, speech-language therapy, durable medical equipment and supplies, and other services.
Special Note: Certain conditions must be met in order for Medicare to cover these services.

Part B (Medical Insurance)
- Covers doctors’ services (except routine physical exams), outpatient medical and surgical services and supplies, diagnostic tests, ambulatory surgery center facility fees for approved procedures, and durable medical equipment. Part B also covers outpatient physical and occupational therapy including speech-language therapy.
- Out-of-pocket costs are the Part B premiums, deductible, copayment, and co-insurance. For durable medical equipment, one is responsible for the first 20% of the Medicare-approved amount.
- Assistive technology devices and services can be covered under the areas of durable medical equipment, outpatient physical and occupational therapy, including speech and language therapy, mental health services, and prosthetics.

HEALTH CARE CHOICES
You may have choices in how you get your health care.

The Original Medicare Plan – This plan is the one described above and is available everywhere in the United States and is the way most people get their Medicare Part A and Part B health care. You may go to any doctor, specialist, or hospital that accepts Medicare. You pay your share, and Medicare pays its share. Some things are not covered, like outpatient prescription drugs and routine or yearly physical exams.

Medicare Managed Care Plans – These are health care choices in some areas of the country. In most plans, you can only go to doctors, specialists, or hospitals on the plan’s list. Plans must cover all Medicare Part A and Part B health care. Some plans cover extras, like prescription drugs. Your costs may be lower than in the Original Medicare Plan.

HOW MEDICARE PAYS
Deductible
The deductible is the first $100 of Medicare “allowed charges” in a calendar year and is the responsibility of the patient. Medicare reimburses for charges after that.

Medicare-Approved Amount
The fee Medicare sets as reasonable for a covered medical service. This is the amount a doctor or supplier is paid by you and Medicare for a service or supply. It may be less than the actual amount charged by a doctor or supplier. The approved amount is sometimes called the "Approved Charge."
**Coinsurance**
The percent of the Medicare-approved amount that you have to pay after you pay the deductible for Part A and/or Part B. In the Original Medicare Plan, the **coinsurance payment is a percentage of the cost of the service** (like 20%).

**Copayment**
In some Medicare health plans, the amount that you pay for each medical service you get, like a doctor visit. A copayment is usually a set amount you pay for a service. For example, this could be $5 or $10 for a doctor visit. Copayments are also used for some hospital outpatient services in the Original Medicare Plan.

**Assignment**
Assignment is when the provider accepts Medicare’s allowed charges as the full fee, rather than the provider’s actual fee.

**Limiting Charge**
The highest amount of money you can be charged for a covered service by doctors and other health care providers who don't accept assignment. The limit is 15% over Medicare’s approved amount. The limiting charge only applies to certain services and does not apply to supplies or equipment.

**Medicare Second Payer**
Sometimes your other insurance pays your health care bills first and Medicare pays second.

**Dual Entitlement**
Medicare is the primary payer in all other cases, including situations of dual entitlement, when Medicare and Medicaid share responsibility. Also, dual entitlement permits the state to pay Medicare’s out-of-pocket expenses (premiums, deductibles, and co-insurance).

**Special Note:** In dual entitlement cases, the law requires health care providers to accept assignment.

If Medicaid is the only payer, however, the provider must accept Medicaid’s reimbursement as the entire payment, and cannot charge the consumer for the remainder of the costs

**ASSISTIVE TECHNOLOGY FUNDING SOURCE**
Assistive technology (AT) devices and services have potential for Medicare funding for Medicare beneficiaries under Part A and Part B. AT devices and services need to be medically necessary and may be covered under the categories of durable medical equipment and speech, physical, or occupational therapy. See below for more specific coverage guidelines:
**Medical Necessity**

Like Medicaid, Medicare will reimburse for various kinds of services and supplies (including assistive technology) as long as they are considered by Medicare to be “medically necessary.” Medically necessary supplies or services:

- Are proper and needed for the diagnosis or treatment of your medical condition;
- Are provided for the diagnosis, direct care, and treatment of your medical condition;
- Meet the standards of good medical practice in the medical community of your local area; and
- Are not mainly for the convenience of you or your doctor.

The following are points of Medical Necessity in the area of durable medical equipment:

1) The equipment must be reasonable and necessary for the treatment of an illness or an injury, or to improve the functioning of a malformed body part.

2) The patient’s diagnosis must warrant the type of equipment or supply being rented or purchased.

3) The physician’s order and/or Certificate of Medical Necessity (CMN) to the supplier must include:
   - The patient’s diagnosis, and
   - The reason the equipment is required, and
   - The physician’s estimate, in months, of the duration of its need.

**Medical Necessity Justification**

When providing medical necessity justification for an assistive technology device or service, the following general principles should be understood:

- The medical purpose of a device is NOT simply to obtain medical treatment for some other impairment, i.e., the need for an augmentative communication device to discuss the status of an ulcer. **Rather, the purpose of the device is to restore the functional ability of the medical condition.**

- A device which is constructed in such a way that it has uses for people without disabilities (such as remote control devices) yet provides the needed and specific treatment regardless of whether or not others have uses for it, does not eliminate it for purchase under the DME definition.

- The cause of the beneficiary’s impairment or disability (e.g. congenital, developmental, acquired) or the beneficiary’s age at the onset of the impairment or disability is not a relevant consideration in the determination of medical need.
• The unavailability of a device, component, or accessory for rental does not serve as a basis for denying a prior approval request for that device, component, or accessory.

**Durable Medical Equipment**

Medicare usually will pay for an assistive device if it can be considered durable medical equipment (DME) and is covered under Title 18. The federal government usually defines durable medical equipment as that equipment which:

- Can withstand repeated use;
- Is primarily used for medical purposes;
- Is generally not useful to a person in the absence of an illness, injury, or disability; and
- Is appropriate for use in the home.

In addition to the above definition, DME items must be necessary and reasonable for the treatment of an illness or injury, or to improve the functioning of a malformed body member.

Medicare covered equipment has certain other unique features:

- Most commonly used home medical equipment, such as wheelchairs, ambulatory aids, hospital beds, heating and decubitus pads, seat lift chairs, stair glides, etc., each have their own very specific coverage criteria. Equipment suppliers are the best sources of this information and most will provide it upon request.

- As of January 1, 2001, augmentative and alternative communication devices or communicators, which are referred to as “speech generating devices” are now considered to fall within the DME benefit category established by 1861(n) of the Social Security Act. They may be covered if the contractor’s medical staff determines that the patient suffers from a severe speech impairment and that the medical condition warrants the use of a device based on the following definitions:
  
  **Speech Generating Devices**—Speech generating devices are defined as speech aids that provide an individual who has a severe speech impairment with the ability to meet his/her functional speaking needs.

  **Speech generating devices are characterized by:**

  - Being a dedicated speech device, used solely by the individual who has a severe speech impairment;
  - May have digitized speech output, using pre-recorded messages, less than or equal to 8 minutes recording time;
  - May have digitized speech output, using pre-recorded messages, greater than 8 minutes recording time;
  - May have synthesized speech output, which requires message formulation by spelling and device access by physical contact with the device-direct selection techniques;
  - May have synthesized speech output, which permits multiple methods of message formulation and multiple methods of device access; or
- May be software that allows a laptop computer, desktop computer, or personal digital assistant (PDA) to function as a speech-generating device.

  - **Excluded Speech-Generating Devices** are appliances that would not meet the definition of speech-generating devices and, therefore, do not fall within the scope of 1861(n). They are characterized by:
    - Devices that are **not** dedicated speech devices, but are devices that are capable of running software for purposes other than for speech generation, e.g., devices that can also run a word processing package, an accounting program, or perform other non-medical functions.
    - Laptop computers, desktop computers, or PDAs, which may be programmed to perform the same function as a speech generating device, are non-covered since they are not primarily medical in nature and do not meet the definition of DME. For this reason, they cannot be considered speech-generating devices for Medicare coverage purposes.
    - A device that is useful to someone without severe speech impairment is not considered a speech-generating device for Medicare coverage purposes.

- Each service or piece of DME that Medicare routinely covers has a special HCFA Common Procedure Coding System (HCPCS) code. Although it does not suit the purpose of this guide to list them here, each DME supplier, which accepts Medicare assignments, has a Medicare Provider Manual which lists these codes.

- Certain equipment which is not customarily purchased by Medicare may, in fact, be covered when the prescribing physician provides a strong enough medical justification for that device. This is true of all insurance carriers when the policy covers DME.

Even if medically necessary, an item **will not be covered** if:

- Its cost is out of proportion to its benefit;
- It is more expensive than an appropriate alternative; or
- It duplicates the purpose of an item already available to the recipient.

**Exclusions**

Sensory aids are also notable exclusions from the inventory of commonly covered products, usually on the basis that the items are for personal comfort or custodial care and not for medical purposes.

There have been cases where Medicare has reimbursed for sensory aids. In each case, however, the criterion of medical necessity, as indicated through a physician’s
prescription, has been critical. Anyone eligible for Medicare coverage should file a claim for funding of communication aids. If the claim is carefully prepared and documented, it has a good chance of being approved.

It should be noted that the Coverage Issues Appendix of the Medicare Carriers Manual is only a set of guidelines for Part B carriers and is not legally enforceable. As such, there is room for interpretation of coverage by each carrier.

**EQUIPMENT PRESCRIPTION & CLAIMS SUBMISSION**

Health care providers and suppliers submit claims for payment of assistive technology devices and services directly to Medicare.

Medicare will only pay for equipment if a physician prescribes it. Although the scope of assistive technology devices and services is limited under Medicare coverage, devices which are medically necessary and therapies necessary for learning to use the device are covered. The usual procedure is as follows:

- A clinician (doctor or therapist) evaluates and identifies the patient’s medical need for a given device.

- The patient receives a prescription from the doctor for the necessary equipment.

- The patient takes the prescription to an equipment supplier who either accepts Medicare assignment for the equipment or requires payment up front and agrees to submit paperwork to Medicare on the patient’s behalf for reimbursement. Either way, the supplier will usually deliver the equipment and must work with the doctor to get the necessary paperwork completed and submitted to the Medicare insurance carrier.

- After the doctor sends the Certificate of Medical Necessity (CMN) to the equipment dealer, the dealer bills Medicare.

**Payment Process**

Medicare assigns an allowable charge to devices and services based on:

- The provider’s customary charge;
- Actual charge; and
- Prevailing charge in the geographical area.

Medicare then pays 80% of the allowable charge. The consumer’s private resources or other insurance must pick up the remaining 20%.

**Least Costly Alternative**

Medicare pays for the “least costly alternative.” A device may have special features that make it more convenient for the user, but more costly as well. When the additional device features are not related to the user’s medical condition, Medicare’s allowable price level is likely to be the cost of the standard, less costly item. If the
standard item is not desirable, it is possible to combine Medicare funds with other resources to obtain the higher priced product when other resources can be found to pay additional costs.

**Special Note to Doctors**

For most Durable Medical Equipment (DME), Medicare requires a Certificate of Medical Necessity (CMN), which contains a description of the patient’s condition/diagnosis, the functional deficit(s) as they relate to the need for the prescribed equipment, and a brief statement of therapeutic benefit. In addition, the CMN must:

- Include the patient’s Medicare identification number;
- Include the precise description of the prescribed equipment and its corresponding HCFA Common Procedure Coding System (HCPCS);

**Special Note:** Medicare has specific criteria for most covered devices. Obtain this and the correct coding information from the equipment supplier **before** completing the CMN. How closely the language used on the CMN matches criteria language is extremely important. Claims processors are not usually medically trained, and often determine medical necessity by word comparison.

- Include the prescribing physician’s **personal signature** and date of signature (Stamped signatures are not acceptable); **and**
- Include the doctor’s Unique Physician’s Identification Number (UPIN).

Under current regulations, neither the beneficiaries nor DME suppliers can complete the CMN. **Only the prescribing physician or someone employed by that physician can complete the CMN.** The equipment supplier may provide the doctor with the CMN and a cover letter describing the necessary equipment codes and Medicare coverage criteria for prescribed device(s).

**Support for Physician Prescription**

As is the case with most insurance carriers, Medicare will only purchase equipment if a physician prescribes it. The doctor may not be as familiar with the technology’s benefit as the therapist or rehabilitation engineer who recommended the device, or family members who have witnessed its effectiveness in various settings. If so, it will be critical for the doctor to ask the patient and family members, the professional(s) recommending the equipment, and DME suppliers to provide the missing information. Only then will the doctor correctly assess the patient’s needs and write an appropriate prescription.

In addition to the doctor’s prescription, Medicare carriers typically encourage suppliers to include any available support documentation, such as statements from allied health professionals and others, when submitting DME claims.
If the Medicare beneficiary or service provider does not agree with Medicare carrier's decision, they have a right to appeal that decision with the insurance carrier. If Medicare denies an equipment claim or fails to reimburse the correct dollar amount, the equipment supplier that accepted assignment will usually attempt an appeal. If not, the beneficiary may wish to do so with assistance from the North Dakota Protection & Advocacy Project and the prescribing physician.

Regardless of who takes the lead, the procedure is quite similar. If consumers have problems getting information about the status of an appeal, they can file a complaint with the Health Care Financing Administration.

- Part B Medicare, the person, or supplier must file a request for review in writing within 6 months of the time the initial decision was made. The final deadline date for appeal, where to send the request, and the reason for denial all appear on the consumer’s Explanation of Medicare Benefits (EOMB) form.

- There are several ways that a valid claim can be denied, and the reason appearing on the EOMB form will not always provide a clear explanation. The typical statements are “not medically necessary” or “not prescribed by a physician.”

A denial under medical necessity could mean one of several things. Perhaps one of the criteria check-offs on the CMN was left blank, or a HCPCS code was missing or incorrect. It could also mean that more information about the patient’s condition is needed.

It is usually helpful to get an additional letter of support from the prescribing physician if a claim is denied as “not medically necessary.” Ideally, this letter would contain additional evidence of the patient's medical/functional need for the prescribed equipment.

The “not prescribed” reason can appear if the doctor fails to date his/her signature or omits the UPIN number.

Equipment dealers usually are very good at detecting what is missing from the CMN and will often assist the doctor in addressing specific points of Medicare coverage criteria. Many denials are reversed upon appeal.

- There is yet another option if the review decision is unsatisfactory and the disputed amount is $100 or more. The consumer or service provider may submit a request for fair hearing. Again, the request must be in writing and must be postmarked within 6 months of the review decision.

Equipment denials that reach this level are often disputes about the medical necessity of the prescribed device(s). A supplementary letter of support from
the prescribing physician is essential at this stage. Again, doctors are encouraged to utilize the equipment suppliers or IPAT for hints about how to make their additional documentation speak directly to the denial issues and Medicare coverage criteria.

- Even the most compelling argument will be ineffective if it does not address the specific reason for denial.

- If fair hearing does not yield satisfactory results, and the amount in dispute is $500 or more, the consumer or service provider may file a request for a hearing before an **Administrative Law Judge (ALJ) within 60 days** of the fair hearing review.

- Although cases do not usually advance beyond ALJ, those that are not resolved at or before that level may be appealed to **Federal Court** if the disputed claim amount is $1000 or more.

**ELIGIBILITY AND ENTITLEMENT:**

Questions regarding Medicare eligibility and entitlement may be directed to your local Social Security office. The address and telephone number are listed in your telephone directory in the government section under Social Security Administration.

**CONTACT INFORMATION**

- For more information regarding appeals contact the Healthcare Financing Administration. See Directory: **Healthcare Financing Administration (HCFA)**.

- For more information regarding Medicare, you can contact the Medicare Help-Line. See Directory: **Medicare Help-Line**.

- The address and telephone listings (including TTY) of other Social Security offices are available upon request from the ND Social Security Administration. See Directory: **Social Security Administration (SSA), Regional Offices**.

- **DME Claims**-All Medicare Durable Medical Equipment (DME) claims in the country are administered by four DME Equipment Regional Carriers (DMERCs). Questions on DME claims can be submitted to the DMERC for the region to which North Dakota belongs. See Directory: **Cigna Medicare**.

- **Regular Medicare Claims**-Questions regarding claims for Medicare Part B services other than DME should be directed to Blue Cross Blue Shield of North Dakota. See Directory: **Blue Cross Blue Shield of North Dakota**.
MEDICARE SUPPLEMENT or MEDIGAP

Although Medicare provides payment for a substantial part of the health care expenses of its beneficiaries, there remain costs for Medicare deductibles, co-insurance, and charges not covered under the Medicare plan. To address these sometimes substantial costs, some people are interested in purchasing supplemental insurance coverage.

Private-for-profit insurers have been limited by the federal government to offering one or more of ten basic Medicare Supplement or Medigap policies, which provide a range of coverage. Medigap policies are not government policies nor are they government-sponsored.

Among other issues to examine when considering the purchase of Medicare Supplemental Insurance, the following relate to assistive technology:

- Coverage for home health services;
- Durable Medical Equipment coverage;
- Rental of equipment and supplies, such as wheelchairs;
- Therapist services (physical, occupational, speech/language/hearing);
- Coverage for mental disorders;
- Vision coverage;
- Coverage for skilled nursing care beyond 150 days and copayment coverage; and
- Hospice benefits.

CONTACT INFORMATION
For further information or to address concerns, contact the North Dakota Insurance Commissioner. See Directory: Insurance Department of North Dakota.

WORKERS’ COMPENSATION INSURANCE

Workers’ Compensation Insurance is insurance coverage for employees who have a work-related illness or injury. In North Dakota, this insurance must be provided when a person, company, or corporation has full or part-time employees. Sole proprietors and partnerships with no employees may not need to provide Workers’
Compensation Insurance. However, if they hire employees, they must provide coverage for their workers.

All states require that employers provide Workers’ Compensation coverage. North Dakota requires that the insurance be purchased through state funds. In other states the employer may have three choices: private insurance, state funds, or self-funding. Regardless of how an employer chooses to provide the coverage, state law mandates the benefits. Therefore, all workers in a particular state have the same benefits.

**ELIGIBILITY**

Individuals who have a work-related illness or have been injured on the job may be eligible for Workers’ Compensation benefits. The laws cover injury or death from accidents “arising out of and in the course of employment.” Most exclude injuries due to the employee’s intoxication, willful misconduct, or gross negligence.

**ASSISTIVE TECHNOLOGY FUNDING SOURCE**

Employers have come to learn that an effective Workers’ Compensation program minimizes the amount of fiscal outlay for non-productive medical expenses and time involved with them. Because an employer’s overriding concern must be employee productivity, rehabilitation activities and assistive technology, which result in a more timely return to productivity, should be available and more quickly obtained through this system than many others.

Workers’ Compensation Insurance benefits fall into three categories and are paid according to the nature and extent of the injury:

1) **Cash benefits**: include disability income payments for partial lost wages and lump sum payments for lost limbs or members.

2) **Medical benefits**: are generally provided from the first dollar of expense and would cover needed assistive technology.

3) **Rehabilitation benefits**: include necessary medical or vocational rehabilitation evaluations, work adjustment, and training for the use of assistive technology.

Assistive technology to function in the workplace, at home in daily living activities, for transportation purposes, and in other areas, should be considered as a part of the rehabilitation plan. Although the primary focus of Workers’ Compensation is return to work, other quality of life functions may now be severely limited by the workplace illness or injury and require consideration. Consequently, assistive technology required in environments other than the workplace should be justified as required to enable the individual to return to the employment environment, as well as complete workplace duties.
APPLICATION PROCESS
When an employee becomes injured on the job and requires medical treatment, he or she must complete the necessary paperwork to report the illness or injury within a reasonable time period, whether or not medical treatment is sought at that time. The employer usually files the initial claim and notice is given to Workers’ Compensation indicating that a claim may be pending. Depending upon the anticipated expense, the insurance company may choose to wait for and pay the medical bill or assign a claims adjuster to manage it. Be aware that the claims adjuster is not necessarily an advocate of the employee.

If assistive technology devices and services are required as a result of the illness or injury, a physician who is treating the illness or injury must verify the medical need. In addition, consumers should speak with the insurance adjuster or service provider to find out whether prior approval is required for durable medical equipment or other assistive technology.

- Employees should inform their employers of a work-related injury within 21 days.

- In work-related illness cases, employees should notify their employers as soon as the employee has knowledge of the illness and its possible relationship to the job.

- It is advisable NOT to be too hasty in settling a claim, or signing a waiver or release form. It will take time to know what kind of assistive technology devices and services will be needed and for what length of time.

APPEALS
If a claim is denied, consumers can file a petition with the Bureau of Workers’ Compensation. Petitions must be filed within 3 years from the date an injury occurred or from the date the employee has knowledge of a work-related illness.

Generally, when a claim is challenged, the Office of Workers’ Compensation will investigate the disputed claim on an informal basis to try to settle the differences. If no agreement can be reached, parties may request a hearing. If an appeal is filed, the director will issue the final administrative decision. If there is still a dispute, either party may appeal the decision to the court of appeals within, generally, 30 working days after the final administrative decision is issued. If a claim is disputed, no cash benefits may be paid until the Office of Workers’ Compensation conducts its investigation, holds a hearing, and renders a decision.

CONTACT INFORMATION
For additional information, contact the Workers’ Compensation Bureau of North Dakota. See Directory: Workers’ Compensation Bureau of North Dakota.
PRIVATE INSURANCE

Private health insurance is a government-regulated business, which is designed to assist covered individuals to pay for medical care. Traditionally, in the United States, the focus has been on acute health care (i.e., immediate treatment of an illness or injury). More recently, preventive and health maintenance have become a focus. Under the current health care system, insurance is not mandated to cover all individuals or to meet all health-related needs of covered individuals.

INSURANCE PROVIDERS
There are many types of insurance providers, including commercial carriers, health maintenance organizations, self-insurance by employers, and preferred provider organizations.

Since insurance companies have focused on acute care needs, they have typically been more willing to fund assistive technology devices which are traditionally considered medical equipment, such as wheelchairs, rather than devices associated with rehabilitative care, such as augmentative communication devices. Furthermore, assistive technology services, such as evaluations and training in the use of the device, generally are not reimbursable.

All insurance companies have underwriting requirements and coverage limitations. Insurance plans vary widely in scope and depth of coverage, making it difficult to generalize about technology coverage. It is extremely important for the consumer to be aware of these requirements and limitations.

Any person who is covered under a group policy or under an individual policy is eligible for the medical services described in the policy. Many health insurance companies bar individuals from enrollment in a plan because of pre-existing conditions or will exclude treatments related to pre-existing conditions. Physical or mental disabilities are frequently considered pre-existing conditions, making it difficult or more costly for individuals with disabilities to access private insurance or limiting the benefits they can receive under private insurance.

ELIGIBILITY
The primary requirement for private insurance eligibility is that premiums are paid. Consumers may purchase coverage directly through company sales representatives or employers. If employees wish to include other family members in the plan, the employee may be responsible for paying a premium for the additional coverage.

Health insurance can be purchased directly from a company by an individual, or more commonly, by an employer for employees and their families.
INSURANCE PLAN SELECTION
If an individual with disabilities is not enrolled in a private health insurance plan and is considering enrollment, it would be wise to consider the following aspects of the plan, particularly if funding for assistive technology might be needed:

- Coverage of durable medical equipment or assistive technology.
- Exclusions for pre-existing conditions. Look for the length of time for the exclusion, whether it is permanent and whether it is automatically renewed.
- Policy renewal. Is the policy guaranteed renewable or could coverage be dropped at the option of the insurance company?
- Is there a “lifetime cap” on the amount the policy will pay?

ASSISTIVE TECHNOLOGY FUNDING SOURCE
Private health insurance may be a source of obtaining assistive technology devices and services. When assistive technology is purchased through private insurance, the assistive technology becomes the property of the individual for whom it was purchased. Since policies vary, it is necessary to check the policy to find out what devices and services are covered (e.g., prosthetics, durable medical equipment, physical therapy, occupational therapy, or speech/language/hearing therapy).

To determine whether an individual is entitled to private insurance coverage for assistive technology, the following questions should be addressed:

Is the child or adult in question covered by the insurance policy?
- Have the premiums been paid according to the schedule?
- Is there a pre-existing condition that is exempted under the policy?
- If a child, is age a factor?

Is the item being sought one that is covered by the policy?
- In private health insurance policies, AT is commonly referred to as Durable Medical Equipment (DME). In addition to the DME clause, AT might be covered by a clause which addresses prosthetics, orthopedic appliances, medical supplies, or vision services and equipment. The policy may also list “exclusions” or items that are not covered.
- Even if a DME clause or similar clause would appear to cover an item, the policy may specifically limit the funding that is available (or a dollar limit) for DME. Insurers may also require a copayment for the purchase of DME.
- Each policy will contain its own definition of DME which may be similar to the following:
  - Is able to withstand use by more than one person;
    - Special Note: This could mean that they would refuse to pay for items such as customized wheelchairs.
  - Is primarily and customarily used to serve a medical purpose; and
Is not useful in the absence of illness or injury.
Some policies also include a statement that the DME is for use in the home.

Is the item being sought medically necessary?
- How “medically necessary” is defined is determined by the individual insurance contract. Most policies use language such as the following:
  - Is consistent with the symptoms or diagnosis and treatment of a condition, disease, ailment, or injury;
  - Is in accordance with standards of good medical practice;
  - Is not for the convenience of the insured.

To respond to each of these questions, it is important to read the actual policy rather than a summary or handbook. It is also necessary to obtain copies of any amendments, riders, or supplemental policies. If the answer to each of the above questions is “yes”, the insurance policy will pay for the AT device, subject to any policy limits, copayments, or deductibles.

MEDICAL NECESSITY
It is important to remember that health insurance was developed to meet the acute care needs of individuals and not for rehabilitation or to improve functional capacity. In addition to exclusion or limitations for pre-existing conditions, health insurance policies also make coverage for services or equipment dependent upon its medical necessity.

While a precise definition of medical necessity is usually not provided in a policy, traditionally it refers to acute care situations, which have been identified by the physician. Generally, in cases involving a disability, only the initial stages of treatment for the disability will be considered to constitute a medical necessity (i.e., that care which is needed to stabilize the health condition of a person affected by a disease, injury, or congenital disorder). It will be within this narrow framework that access to assistive technology via private health care, as it exists now, will be viewed.

DURABLE MEDICAL EQUIPMENT
Although insurance policies probably will not refer to assistive technology devices as “assistive technology,” they may provide coverage of durable medical equipment and prostheses. These categories may include the needed assistive technology. For example, a survey of private insurance providers showed that the purchase of prostheses, such as artificial limbs and eyes, and the rental of durable medical equipment, such as wheelchairs, hospital beds, and artificial respirators, would be covered.

Some policies cover physical therapy, occupational therapy, and speech & language therapy, and could, therefore, be interpreted to cover some assistive technology services.
Generally, there will be specific provisions governing the repair, maintenance, and replacement of equipment purchased through an insurance policy. These usually must be linked to a medical justification.

SUCCESSFUL ASSISTIVE TECHNOLOGY CLAIM PREPARATION
Funding success is greatly dependent upon the ability to document medical necessity. The individual requesting funding must:

1) Indicate how a functional limitation is attributable to an illness or injury or describe assistive technology as a prosthesis that replaces a nonfunctioning body part.

2) Ensure that the medical documentation and prescription for the assistive technology describe the medical need in terms that fit the policy guidelines. Emphasis should be placed on cost effectiveness, investment in the beneficiary’s future productivity, and reduction in the future health care costs because of enhanced safety and health. Language describing the requested assistive technology in terms of the comfort or convenience should be avoided!

3) Try to get a case manager for the insured. Insurance companies in cases involving long-term illness and high cost care use case management. Equipment and services, which are included in the individualized case plan, are presumptively accepted for payment under the policy. A case manager will typically have the authority to grant a waiver from certain policy exclusions, thereby allowing the beneficiary to access services and equipment which would not otherwise be available. An added benefit of having a case manager is that many of them are rehabilitation specialists and nurses who are trained to understand disabilities and see cost-effectiveness of assistive technology.

4) It is also helpful to include letters from professionals, other than physicians (e.g., occupational or physical therapists), to document the need for the device(s).

Special Note: Assistive technology may be covered under a major medical back-up policy if it is not covered under a primary insurance plan.

APPEALS
If a consumer is not satisfied with the claim decision, several appeals rights exist. The North Dakota Protection & Advocacy Project is available to provide assistance in the appeals process.

- Appeals directly to the insurance company
  The policy will most likely describe how to appeal an adverse decision. Look for the procedure as well as any time limits. With some policies, a phone call to the insurer may initiate the appeal, while others may require a written appeal.
• **Court appeals**
  Most appeals will be filed in state court.

• **Complaint filed with state insurance agency**
  Determine the proper procedure by contacting the state insurance agency. At that time, it is important to ask what the agency authority is in responding to your complaint.

**CONTACT INFORMATION**
For more information regarding appeals, contact the North Dakota Protection & Advocacy Project. See Directory: *Protection & Advocacy Project*. For answers to specific private insurance policy questions, contact an insurance company agent. To obtain further information about private health insurance providers in North Dakota, contact the Insurance Department of North Dakota. See Directory: *Insurance Department of North Dakota*. 
SOCIAL SECURITY ADMINISTRATION

The Social Security system provides a minimum “floor of protection” for retired workers, and for workers and their families who face a loss of income due to disability or the death of a family wage earner. Social Security was designed as a supplement to other retirement plans such as pensions, savings, and investments. Although the Social Security Administration oversees all of the following programs, each is quite different:

- Retirement Benefits (“Social Security”)
- Social Security Disability Insurance (SSDI)
- Supplemental Security Income (SSI)

Social Security Retirement and disability insurance are programs that workers, employers, and the self-employed pay for with their Social Security taxes. You qualify for these benefits based on your work history and the amount of your benefit is based on your earnings.

Supplemental Security Income is a program financed through general tax revenues—not through Social Security trust funds. SSI disability benefits are paid to people who have a disability and don’t have a lot of income.

ASSISTIVE TECHNOLOGY FUNDING SOURCE

The Social Security Administration provides limited monthly income supplements, but does not pay for assistive technology devices and services directly. Assistance is in the form of cash disability income payments, which can be used to purchase necessary assistive technology devices and/or services.

RETIREMENT BENEFITS (“SOCIAL SECURITY”)

Social Security pays monthly retirement benefits to retired workers and their family members. Full retirement benefits are now payable at age 65, with reduced benefits available as early as age 62.

ELIGIBILITY

Family members who qualify for Retirement Benefits include:

- A spouse 62 years of age or over,
- Spouse of any age who is taking care of the retiree’s child who is under the age of 16 or has a disability,
- Former spouse, age 62 or over, if the marriage lasted for 10 or more years,
- Children, stepchildren, adopted children, and sometimes grandchildren up to age 18 (age 18-19, if they are full-time students through grade 12),
Children over age 18 who have disabilities, which occurred prior to age 22. This category is an important one for certain adults with disabilities. These individuals are qualified to receive benefits under their parents’ earning records.

SURVIVORS’ BENEFITS
Some family members of deceased wage earners are entitled to benefits called Survivors’ Benefits.

- A son or daughter with disabilities of a deceased worker may receive benefits indefinitely (or until the condition goes away) if the onset of the disability occurred prior to age 22. Those who do not have disabilities can receive similar benefits up to age 18. The deceased family member must simply have paid taxes for the required number of years.

- A surviving spouse with disabilities (or ex-spouse with disabilities if the marriage lasted 10 years or more) qualifies if:
  - The surviving person is age 50 or above (one who does not have disabilities must be age 60 or above);
  - The disability of the surviving spouse started before the original beneficiary died, or within 7 years after death; or
  - The surviving spouse caring for the deceased’s children and receiving benefit payments develops disabilities before those payments end (for example, when the child turns 18 or within 7 years after death).

SUPPLEMENTAL SECURITY INCOME
Supplemental Security Income (SSI) is a federal program that provides a minimum monthly payment to people who have limited income and resources if they are 65 years of age or older or if they have blindness or another disability. SSI is designed to assist persons with disabilities who have little income or no other resources. People who receive SSI usually receive food stamps and Medicaid also.

ELIGIBILITY
Individuals eligible for Supplemental Security Income benefits include those who:
- Are age 65 or older;
- Have blindness;
- Have disabilities;
- Are residents of one of the 50 states, DC, or the Northern Mariana Islands;
- Are US citizens or legally admitted aliens for permanent residence;
- Have no countable income for one month or more; or
• Have no countable resources in excess of $1500 for one person or $2500 for two persons.

Blindness
According to these standards, blindness means having no vision or very poor eyesight. Children, as well as adults, can get benefits because of blindness.

Disabilities
Under Social Security, workers are considered to have disabilities if they have a severe physical or mental condition which prevents them from working. The condition must be expected to last for at least 12 months or to result in death.

Children, as well as adults, can get benefits because of a disability. When deciding if a child has disabilities, Social Security looks at how the disability affects the child’s ability to do the things, and behave in the ways, that a child of similar age typically would.

INELIGIBILITY
A person may not be eligible for SSI if he/she is:
• Residing in a public institution and not receiving Medicaid;
• Not willing to accept treatment for drug or alcohol addiction;
• Absent from the United States;
• Refuses to accept Vocational Rehabilitation services; or
• Refuses to apply for other benefits or pensions for which he/she is eligible.

SOCIAL SECURITY DISABILITY INSURANCE
Social Security Disability Insurance (SSDI) is a social insurance program that provides monthly cash benefits to those who are eligible.

ELIGIBILITY
Only people with one or more disabilities qualify and the following additional requirements must be met:
• The disability must prevent the person from earning above a certain income level called the Substantial Gainful Activity Level (SGA) level. A person with a disability who earns below the SGA level is eligible for SSDI benefits.

• The person must have achieved insured status by having paid in to the Social Security system for at least half of the quarters in the ten years preceding the onset of their disability.

• The person must accept Vocational Rehabilitation services if they are offered.
ISSUES FOR INDIVIDUALS WITH BLINDNESS
The computations for deductions from income are different for individuals with blindness. SSI allows more deductions and more specific deductions. Some examples of blind work expenses are guide dog expenses, transportation to and from work, taxes, vision and sensory aids, professional association fees, union dues, and translation of materials into Braille or electronic format.

APPLICATION PROCESS
If you think you may be eligible for Social Security Retirement Benefits, Supplemental Security Income, Social Security Disability Insurance, or a combination of these, call 1-800-772-1213, or contact your local Social Security Office to file a claim.

Social Security wants to make the application process as easy as possible. The entire application can be taken over the phone or through the mail or, if preferred, through a visit to one of the community offices.

WORK INCENTIVES PROGRAMS
Through several of the work incentive programs available in the Social Security Administration, indirect funding can be obtained for assistive technology if the equipment is in some way related to getting or keeping a job, and include:

SUBSIDY is available if the assistive technology is funded by the employer or if training to use the assistive technology takes place on the job. It could also be available if an individual performs fewer tasks than someone else in the same job or if productivity is reduced even with the use of technology.

IMPAIRMENT-RELATED WORK EXPENSES (IRWE) allows money to be set aside from income to pay for equipment or services a person may need in order to work, even if these items and services are also needed for non-work activities. The person must not have been, nor expect to be, reimbursed for the expenses.

PLAN TO ACHIEVE SELF SUPPORT (PASS) is another way of setting income aside to purchase assistive technology devices and/or services. It allows a person with a disability to set aside income for a specified amount of time in order to reach a work goal.

BLIND WORK EXPENSES (BWE) are available to working persons with blindness. Earned income can be used for work-related expenses for equipment of any type and not necessarily needed because of blindness, and the amount is deducted from countable earned income.
**TRIAL WORK PERIOD** lets people test their ability to work or run a business for at least 9 months in spite of their disability without affecting their disability benefits.

**APPEALS PROCESS**
If a claim for benefits is denied for any reason, the applicant has the right to appeal that decision. Submission timeframes are similar to those of public insurance carriers, such as Medicare and Medicaid, but the process itself is somewhat different.

**Stage One: Request for Review**
A Request for Review must be submitted in writing within 60 days of the denial. The claimant has the right to review their claim file upon request and to submit new information that may have a bearing on the eligibility decision. Such information should be included or referenced in the letter of request for review.

**Stage Two: Request for Hearing**
If the claim is denied at the review stage, the claimant may file for a hearing. The request must be made within 60 days of the review decision, and the claimant has a right to be accompanied by an advocate or representative at the hearing. Any new and relevant information should be submitted at the time of the request.

**Stage Three: Appeals Council**
A hearing denial can be appealed to a council for review upon request.

**Stage Four: New Application or Court Case**
If the Council sustains the denial, the only recourse is to take the case to court or to file a new application.

**CONTACT INFORMATION**
The Assistive Technology Funding & Systems Change Project has excellent, comprehensive resource materials regarding the Social Security programs. See Directory: Assistive Technology Funding & Systems Change Project. The Social Security Administration also is available to answer your questions. See Directory: Social Security Administration (SSA). North Dakota has 4 district managers located at one of 4 regional offices that can also answer your questions. See Directory: Social Security Administration (SSA), Regional Offices.
VETERANS’ ADMINISTRATION

The United States Department of Veterans Affairs (VA) is designed to provide comprehensive health care to veterans with service related disabilities and to some veterans whose disabilities are not service related.

Veterans who have disabilities and who do not have a dishonorable discharge status from military service may be eligible for benefits that include the provision of assistive technology devices and services through Veterans Affairs of North Dakota.

ELIGIBILITY
Eligibility for health benefits through the Veterans Administration (VA) is available to veterans of active military service who have been honorably discharged or who received a general discharge from military service. Individuals who receive dishonorable discharges are not eligible for VA benefits. Benefits may also be paid to veterans’ survivors and, in some cases, to dependents of living veterans.

Certain VA benefits and medical care require wartime service. Those who complete at least six years of honorable service in the Selected Reserves may receive home-loan benefits even if they were not active service members. Veterans who have non-service-connected disabilities, such as late onset diabetes, are entitled to pension benefits, which may include certain assistive technology devices, such as prosthetics.

ASSISTIVE TECHNOLOGY FUNDING SOURCE
The Veterans’ Administration is one of the largest purchasers of assistive technology for individuals with disabilities. The primary goal of the VA is to ensure cost-effective procurement of equipment that is both needed by, and safe for, eligible veterans.

The programs through which assistive technology is available include:

- Vocational rehabilitation and education programs;
- Prosthetics and other medical supplies;
- Grants for automobiles and automobile adaptations; and
- Loans and grants for adapted homes and adaptations to existing homes.

The VA pays for patient lifts, hospital beds, wheelchairs, communication devices, and artificial limbs, and often provides a clothing allowance to replace veterans’ clothing, which has been damaged or worn through the use of assistive technology devices.
The VA also commits considerable resources to education and training of clinical personnel in the capabilities of assistive technology. It supports a nationwide staff of equipment purchasing specialists and invests in research and development, evaluation, and development of guidelines for assistive technology.

**APPLICATION PROCESS**

To file applications for VA benefits and, for those who qualify, to begin the assistive technology procurement process, contact a Veterans’ Service Officer located in each county.

**VETERANS’ ADMINISTRATION MEDICAL CENTERS**

The VA’s medical centers (VAMCs) are primary features of VA service provision. VAMCs are located throughout the country and deliver inpatient and outpatient services, including assistive technology, to veterans in their areas. VAMCs, which specialize in specific services, such as blindness, serve as referral sites for particular cases from a larger region.

The VAMCs have staff responsible for evaluations and making determinations regarding needed products and services. The physician, however, has ultimate responsibility and must provide a prescription authorizing required devices and services.

**APPEALS PROCESS**

If claims for benefits are not accepted, or if veterans disagree with denials of requests for assistive technology, an appeal can be filed with Veterans’ Affairs of North Dakota.

An appeal of the VA decision must be made within one year of notification of the decision.

- The claimant should file a written notice of disagreement with the office that made the decision.
- That office, in turn, will provide the veteran with a **Statement of the Case** stating the issue, facts, applicable law and regulations, and the reason for the determination.
- Within 60 days of receiving the Statement of Case, or within one year from the notice of the original determination (whichever is later) the veteran must file a **Substantive Appeal** with the Board of Veterans’ Appeals.
- The Board of Veterans’ Appeals hearing will be held in Washington, DC, or at a VA Regional Office. An advocate or attorney may represent the claimant. This Board will conduct the appeal and issue a written decision.
• The decision, if unsatisfactory, may be appealed to the Court of Veterans’ Appeals, which is a seven-judge court separate from the VA. This appeal must be filed within 120 days of the date of the Board’s final decision. No new evidence may be provided at this level.

• Either party may appeal the Court’s decision to the US Federal Court of Appeals and to the US Supreme Court.

CONTACT INFORMATION
For additional information about Veterans’ benefits, contact a Veteran Services Officer (see local telephone directory under County Government) or Veterans’ Affairs of North Dakota. See Directory: Veterans’ Affairs of North Dakota.
ALTERNATIVE FUNDING SOURCES

When funding for assistive technology devices and services is not available from more traditional funding sources, a number of other avenues may be pursued. Health and disability organizations, service clubs, fraternal organizations, foundations & trusts, equipment manufacturers, and other community entities can be sources of funding for assistive technology. Sometimes a personal financial loan or a tax incentive would be a preferable funding alternative.

These entities typically represent a membership, family, or other group of people who have come together with a philanthropic purpose. Their approach is generally less formal than that of large entities, and they tend to provide smaller and very specific monetary awards. Most often these groups will provide funding for individuals who fall through the cracks and who have exhausted public sources of funding. The focus and requirements for national organizations may be quite different from those at local levels and it may be beneficial to pursue the potential of each.

HEALTH AND DISABILITY ORGANIZATIONS

Health and disability organizations provide different kinds of assistance for obtaining assistive technology devices and services for individuals with disabilities. Some provide information, counseling, referral, and sometimes financial assistance for the purchase of the devices and/or services. Following are descriptions of several available in North Dakota:

**North Dakota Association for the Disabled**
The North Dakota Association for the Disabled (NDAD) is a nonprofit, charitable organization founded by concerned citizens for the purpose of assisting the mentally and physically disadvantaged within North Dakota, many of whom are not eligible for services from other agencies. Although unable to grant every request, NDAD provides financial assistance in purchasing specialized equipment, medical treatment, and other services.

**Easter Seal Society of North Dakota, Inc.**
The purpose of this group is to provide services and opportunities, which enhance the lives of people with disabilities and their families. The society believes this goal is accomplished by fostering self-determination, integration, and independence. The Easter Seal Society serves all people with all types of disabilities. Individuals are determined eligible for services by the Department of Human Services. For those who don’t qualify, a self-pay program is available. Services include: community awareness, equipment loan, homemaker and home health aide services, recreation, personal/attendant care, staff training, family support services, and disability awareness.
Hear Now
This organization disseminates donated, reconditioned hearing aids or cochlear
implants to low-income people with hearing impairments through their National
Hearing Aid bank. North Dakota is affiliated with Hear Now through a statewide
program called Hear-O.

OTHERS TO CONSIDER…
• National Easter Seal Society
• Multiple Sclerosis Society
• Muscular Dystrophy Association
• Spinal Cord Injury Association
• The Braille Institute
• March of Dimes

CONTACT INFORMATION
For further information regarding North Dakota Association for the
Disabled (NDAD) and Hear-O, see the Directory. See Directory: North
Dakota Association for the Disabled (NDAD) and Hear-O Program. For further
information regarding any of the other organizations mentioned, see your local
telephone book.

SERVICE CLUBS & FRATERNAL ORGANIZATIONS

Local civic clubs and fraternal organizations often contribute to the purchase of
assistive technology by setting aside or raising money to help people with disabilities
obtain the equipment needed. These non-profit organizations often have specific
mission statements that direct their activities and may target only certain types of
disabilities or age groups.

Because chapter activities of individual groups vary, individuals who wish to pursue
this potential funding avenue will find it beneficial to contact the group’s national
headquarters also. Information to obtain includes: chapter locations, goals of
specific chapters, “pet” projects, eligibility, and application processes.

Sertoma Clubs
The primary service project for this volunteer civic service organization is to help
people with speech and hearing disorders. They hold fundraisers to support these
service programs each year.

Lions Clubs
Although this group is most often associated with vision-related causes, it also has
supported programs for people who have physical or developmental disabilities, the
elderly, and people who are underprivileged. They pioneered the Canine
Companions for Independence which trains and provides assistance dogs to help
people with disabilities other than blindness, i.e., those who have deafness or hearing impairments, developmental disabilities, emotional disabilities, or physical disabilities.

**Optimist Clubs**
This club often supports “at-risk” children, while the Senior Optimist Club generally targets individuals with speech and hearing difficulties.

**Kiwanis**
The most significant focus for Kiwanis is young children, especially through age five.

**Rotary**
Rotary has a range of target activities which include, but are not limited to: home safety, assistance to the aged and the youth, people with disabilities, playgrounds/recreation, literacy, and community & vocational services.

**Elks Lodges**
This organization supports children and adults with disabilities and special needs. The Elks of North Dakota have established and maintain Elks Camp Grassick for children with a range of disabilities.

**Civitan**
Civitan groups encourage good citizenship and community service and could be approached to consider assistive technology funding for people with disabilities enabling them to participate in communities and demonstrate good citizenship.

**Masons and Shriners**
These organizations focus on support for children with orthopedic disabilities and/or burns. They provide significant funds and assistance for wheelchairs, other mobility equipment, surgical procedures and related costs, and numerous other devices and services.

**Knights of Columbus**
The Knights of Columbus provides support for children with disabilities, including children with cognitive delays.

**OTHERS TO CONSIDER...**
- Eagles Clubs
- Jaycees
- Moose Lodges
- Quota Club
- American Legions

**CONTACT INFORMATION**
For further information, contact your local service organization.
Numerous foundations and trusts provide financial support for a variety of disability-related issues. Most support specific target populations and/or geographic areas.

Many people put part of their estate into a trust fund for a specific purpose. There may be one to assist people with disabilities at a bank in your area. Banks don’t usually advertise this information, however. To determine whether there are any such funds in your area, contact the trust division of each bank.

Corporations often provide funding to non-profit organizations through foundations. It is possible, however, for individuals to work with local non-profits to apply for grants from foundations as a means to acquire assistive technology. The “Foundation Directory,” located in most major libraries or online, will provide necessary information including: eligibility criteria, the application process and deadlines, and more. Here are just a few to consider:

**Muscular Dystrophy Family Foundation**
This foundation is available to assist families when dollars are simply not available or sufficient to cover the costs of needed adaptive equipment. Services are available to individuals having a range of neuromuscular diseases, including muscular dystrophy.

**Wishmakers**
Percy Ross, author of “The Millionaire” newspaper column. Send requests to him in care of a newspaper that carries the column.

**Sunshine Foundation**
This Philadelphia-based organization grants wishes to children with terminal or chronic illnesses, including spina bifida, AIDS, muscular dystrophy, and many more.

**Disabled Children’s Relief Fund**
This entity can provide equipment, prostheses, and rehabilitative services to children with disabilities (ages 0-18) who do not have health insurance. Preference is given to children with physical challenges.

**Sertoma Foundation**
The Sertoma Foundation believes that universal communication, whether heard, seen, or spoken, is the key to human understanding. The purpose of this foundation is to support approved charitable and educational programs through effective fund raising, investment of funds, and the distribution of proceeds.

**Otto Bremer Foundation**
The mission of this foundation is to be an accessible and responsible financial resource to aid in the development and cohesion of communities within the states of Minnesota, North Dakota, Wisconsin, and Montana, with preference given to those
served by affiliates of Bremer Financial Corporation. Grants are restricted to private nonprofit or public tax-exempt organizations and are not made to individuals. Requests for grants for annual fund drives, benefit events, camps, and sporting or recreational activities are discouraged. Although it does fund some post-secondary programs, it does not fund K-12 education. Call 1-888-291-1123 for more information.

OTHERS TO CONSIDER…
- North Dakota Elks Charitable Trust
- Epilepsy Foundation
- Retinitis Pigmentosa (RP) Foundation
- The Rotary Foundation Endowment Fund

NOT TO BE OVERLOOKED . . .
Other entities may also provide assistance in obtaining assistive technology through volunteer efforts. Although they might not provide actual funds, they may donate their time and expertise, provide the material and labor to construct adaptations, organize fund-raisers, provide transportation or equipment/device training, or may provide many other valuable services.
- Catholic Charities
- Chambers of Commerce
- Local churches
- Schools
- Employers
- Labor Unions
- Aid Association for Lutherans (AAL)
- Sororities & Fraternities
- Veterans’ groups
- Equipment manufacturers and vendors

CONTACT INFORMATION
For further information regarding any of these organizations, contact them directly. When pursuing information via the Internet, helpful search words include: associations, charitable, philanthropic organizations, foundations, trusts, clubs, and community organizations. Referencing “disability” can narrow the search.

SPECIAL FINANCING PLANS
A variety of specially designed loan agreements are offered through many banks and lending institutions in North Dakota. The purpose of these programs is to make financing more readily available to help meet the special living needs of individuals with disabilities.
Financing is often needed for home modifications, automobiles and vans, vehicle adaptations, assistive devices, and independent living aids to enable individuals with disabilities to live more comfortably, more independently, and more productively.

**ELIGIBILITY**

Generally, applicants are eligible for these special financing plans if they have a physical or mental impairment that substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such impairment. Major life activities include seeing, hearing, speaking, walking, breathing, performing manual tasks, learning, caring for oneself, and working. An individual with epilepsy, paralysis, severe disfigurement, HIV infection, AIDS, a substantial hearing or visual impairment, mental retardation, or a specific learning disability is covered, but a person with a minor, non-chronic condition of short duration, such as a sprain, broken limb, or the flu, generally would not be covered.

**TYPES OF PLANS**

Varied special financing plans are available and include, but are not limited to, the following:
- Reduced or No Down Payment Plans
- Special Credit Terms
- Automobile/Van and Adaptation Packages
- Home Improvement Loans
- Reverse Mortgages
- Motorized Wheelchair Financing Plans
- Special Credit Terms for Assistive Devices

**CONTACT INFORMATION**

For specific information about eligibility, and special programs designed to assist in the financing of adaptive devices and accommodations for people with disabilities, contact your local lending institution, or the North Dakota Department of Banking and Financial Institutions. See directory: Department of Banking and Financial Institutions.

**NORTH DAKOTA’S AT FINANCIAL LOAN PROGRAM**

The Interagency Program for Assistive Technology (IPAT) and the North Dakota Association for the Disabled (NDAD) has established North Dakota’s Assistive Technology Financial Loan Program. This program, which is modeled after similar programs in other states, makes unsecured personal loans available through First National Bank for the purchase of assistive technology devices needed to increase an individual's independence and level of participation.
There are no minimum or maximum income eligibility requirements; however, applicants must demonstrate their ability to repay the loan. As the loans are paid back, funds will be available to lend to others.

Any North Dakota resident who has, or is a family member of someone who has, a physical or mental impairment that substantially limits one or more major life activities, is eligible to apply for a loan through this program.

**CONTACT INFORMATION**

For specific information about the ND AT Financial Loan Program, contact IPAT or NDAD. See directory: *Interagency Program for Assistive Technology (IPAT) or North Dakota Association for the Disabled (NDAD).*

**UNITED STATES TAX CODE**

The United States Tax Code could also be considered as a source of funding for assistive technology devices and services. Deductions exist which may offset some or all of the costs of assistive technology for individuals with disabilities and their families and for businesses. Investigation of one or more of the following could prove beneficial:

- Medical Care Expense Deductions
- ADA Credit for Small Businesses
- Credit for Architectural & Transportation Barrier Removal
- Targeted Tax Credits
- Charitable Contributions Deductions

**IMPAIRMENT RELATED WORK EXPENSES**

The Impairment Related Work Expenses (IRWE) deductions enable individuals with disabilities who are employed to deduct work expenses from their gross incomes. These expenses must be necessary to maintain employment, must be paid by the employed individual, and may not be reimbursed by any other source.

**CONTACT INFORMATION**

The Internal Revenue Service will be able to provide preliminary information about current tax provisions, but contacting a tax preparer having specific experience with disability areas may provide more detailed information. See Directory: *Internal Revenue Service.*
ASSISTIVE TECHNOLOGY LEMON LAW

The North Dakota Assistive Technology Device Warranties Act (the AT Lemon Law) became effective on August 1, 1997. It provides recourse for the purchaser when a device is defective or does not meet the person’s needs adequately.

Under the Act, assistive technology devices can include many things, such as:

- Wheelchairs
- Magnification systems
- Communication devices
- Computer equipment
- Environmental control systems
- Software

The AT Lemon Law **DOES NOT** cover:

- Hearing aids
- Eye glasses
- Dental prostheses
- Surgical implants
- Devices altered by consumer design

When buying or leasing an assistive technology device, the purchaser should receive a written guarantee. If one is not provided, the consumer should ask for one. With or without a written guarantee, the AT Lemon Law says that the device is guaranteed for at least one year.

A problem with the device must be reported to one of the following before the end of the guarantee:

- The manufacturer, or
- The business leasing the device, or
- The business that sold the device.

It is recommended that the report be made in writing, with the consumer keeping a copy for his/her own records.

The manufacturer or business may be able to repair the device. They may attempt, up to four times, to fix the returned device as long as the total repair time is less than 30 days. If the repairs take ten days or more, the consumer is entitled to a “loaner” device at no cost while the repairs are being completed.

If the device cannot be repaired, it should be returned to the company. The consumer may receive either:

- A replacement device, or
- A full refund, including any finance charges and transaction costs, such as shipping.
CONTACT INFORMATION
For more information or for assistance in working through this process, contact the Protection & Advocacy Project. See Directory: *Protection & Advocacy Project.*
DIRECTORY

AGING SERVICES
Administrative Offices
Dacotah Foundation Building
600 South Second Street, Suite 1C
Bismarck, ND  58504
1-701-328-8910
1-800-451-8693

Regional Human Service Center Offices
(See Directory:  Human Service Center Offices, Regional)

AMERICANS WITH DISABILITIES ACT (ADA)
Department of Human Services
Dacotah Foundation Building
600 South Second Street, Suite 1B
Bismarck, ND  58504
1-701-328-8957 (Voice)
1-701-328-8969 (TTY)

ASSISTIVE TECHNOLOGY FUNDING & SYSTEMS
CHANGE PROJECT
United Cerebral Palsy Associations
1660 L Street, NW, Suite 700
Washington, DC   20036
1-800-872-5827

ASSISTIVE TECHNOLOGY HELP-LINE
1459 Interstate Loop
P.O. Box 160
Bismarck, ND  58502
1-800-472-2911

BLUE CROSS BLUE SHIELD OF NORTH DAKOTA
4510-13th Avenue SW
Fargo, ND  58102
1-800-342-4728
1-701-277-2227

CENTERS FOR INDEPENDENT LIVING
Dakota Center for Independent Living
3111 E. Broadway Avenue
Bismarck, ND  58501
1-701-222-3636
1-800-489-5013

Freedom Resource Center
3505 South 8th Street – Suite 7
Moorhead, MN 56560
1-800-450-0459

Independence, Inc.
900 N. Broadway – Suite 302
Minot, ND 58701
1-800-377-5114
1-701-839-6561 (TTY)

Options
318 – Third Street NW
East Grand Forks, MN 56721
1-800-326-3692

CIGNA MEDICARE
1-800-899-7095
1-800-970-7494 (TTY)
1-615-782-4500
1-615-782-4415 (TTY)

CLIENT ASSISTANCE PROGRAM (CAP)
Dacotah Foundation Building
600 South Second Street, Suite 1B
Bismarck, ND 58504
1-800-207-6122
1-701-328-8947

DEPARTMENT OF BANKING & FINANCIAL INSTITUTIONS
600 East Boulevard, 13th Floor
Bismarck, ND 58505-0080
1-701-328-2253

DEVELOPMENTAL DISABILITIES
Administrative Offices
Dacotah Foundation Building
600 South Second Street, Suite 1A
Bismarck, ND 58504
1-800-755-8529
1-701-328-8930
Regional Human Service Center Offices
(See Directory: Human Service Center Offices, Regional)

EDUCATION
Administrative Offices:
Department of Public Instruction
600 East Boulevard, 11th Floor
Bismarck, ND 58505-0440
1-701-328-2260

Developmental Disabilities, Part C
Dacotah Foundation Building
600 South Second Street, Suite 1A
Bismarck, ND 58504
1-800-755-8529
1-701-328-8930

Special Education, Part B
Department of Public Instruction
600 East Boulevard, 10th Floor
Bismarck, ND 58505-0440
1-701-328-2277

HEALTHCARE FINANCING ADMINISTRATION (HCFA)
Region VIII
Federal Office Building
1961 Stout Street
Denver, CO 80294

HEAR-O PROGRAM
1459 Interstate Loop
P.O. Box 160
Bismarck, ND 58502
1-701-255-3692, ext. 116
1-800-472-2911

HUMAN SERVICE CENTER OFFICES, REGIONAL
Badlands Human Service Center
117 First Street East
Dickinson, ND 58601
1-888-227-7525
1-701-227-7574 (TTY)

Lake Region Human Service Center
200 Highway 2 SW
Devils Lake, ND 58301
1-701-662-7581 (Voice)
1-701-662-3404 (TTY)

North Central Human Service Center
400 – 22nd Ave. NW
Minot, ND 58703
1-888-470-6968
1-701-857-8500
1-701-857-8666 (TTY)

Northeast Human Service Center
151 South 4th Street, Suite 401
Grand Forks, ND 58201
1-701-795-3000
1-701-795-3060 (TTY)
Crisis Center
1-800-845-3731

Northwest Human Service Center
316 Second Avenue West
PO Box 1568
Williston, ND 58802-1568
1-701-774-4600 (Voice)
1-701-774-4692 (TTY)

South Central Human Service Center
520 Third Street NW
PO Box 2055
Jamestown, ND 58402-2055
1-800-260-1310
1-701-252-2641 (Voice/TTY)

Southeast Human Service Center
2624 Ninth Avenue SW
Fargo, ND 58103-2350
1-800-342-4900
1-701-298-4459 (Voice)
1-701-298-4450 (TTY)

West Central Human Service Center
600 South Second Street
Bismarck, ND 58504
1-701-328-8800 Voice/TTY

INSURANCE DEPARTMENT OF NORTH DAKOTA
North Dakota Insurance Commissioner
INTERAGENCY PROGRAM FOR ASSISTIVE TECHNOLOGY (IPAT)

IPAT Central Office
Judie Lee, MS, ATP
Director
PO Box 743
Cavalier, ND  58220
1-800-265-IPAT (4728)
1-701-265-4807 (Voice/TTY)
jlee@polarcomm.com

IPAT Regional Coordinators & Offices
Mike Bishop
Southeast Regional Coordinator
P.O. Box 665
Valley City, ND  58072-0665
1-800-265-4728
1-701-845-8628
mikebishop@valleycity.net

Jeannie Krull, MS/CCC-SLP
Northeast Regional Coordinator
Black Building
118 Broadway, Suite 300
Fargo, ND   58102
1-800-265-4728
1-701-239-7228
jmkrull@fargocity.com

Peggy Shireley, M.Ed., ATP
Southwest Regional Coordinator
4007 State Street #101
Bismarck, ND  58501
1-800-265-4728
1-701-328-9544
shireley@btigate.com

Dud Zimmerman
Northwest Regional Coordinator
400 – 22nd Ave. NW
Minot, ND  58703
1-800-265-4728
1-701-857-8630
dud@minot.com

INTERNAL REVENUE SERVICE
1-800-829-1040
1-800-429-4059 (TTY)

MEDICAID OF NORTH DAKOTA
Medical Services Division
600 East Boulevard Avenue
Bismarck, ND 58505-0261
1-800-755-2604
1-701-328-2321

MEDICARE HELP-LINE
1-800-MEDICARE (633-4227)
1-877-486-2048 (TTY)

NORTH DAKOTA ASSOCIATION FOR THE DISABLED (NDAD)
1913 South Washington St.
Grand Forks, ND 58201
1-701-775-5577

OFFICE FOR CIVIL RIGHTS (OCR)
US Department of Education
Federal Building
1244 Speer Boulevard – Suite 310, 08-7010
Denver, CO 80204-3582
1-303-844-5695
1-303-844-3417 (TTY)

PROTECTION & ADVOCACY PROJECT
Administrative Office
400 East Broadway, Suite 616
Bismarck, ND 58501
1-800-472-2670
1-800-366-6888 (TTY)
1-701-328-2950

SENIOR INFO-LINE
North Dakota Aging Services
600 South Second Street, Suite 1C
Bismarck, ND 58504
1-800-451-8693
SERVICES FOR THE OLDER BLIND
Administrative Office
Dacotah Foundation Building
600 South Second Street – Suite 1B
Bismarck, ND  58504
1-800-755-2745
1-701-328-8950

SOCIAL SECURITY ADMINISTRATION (SSA)
Federal Office
6401 Security Boulevard
Baltimore, MD  21235
1-800-772-1213
1-800-325-0778 (TTY)

Regional Offices
Social Security Administration
1680 East Capitol Avenue
Bismarck, ND  58501
1-701-250-4200

Social Security Administration
657-2nd Avenue North
Fargo, ND  58102
1-701-239-5607

Social Security Administration
124 North 6th Street
Grand Forks, ND  58203
1-701-772-5518

Social Security Administration
Room 104, Federal Building
100-1st Street SW
Minot, ND  58702
1-701-852-3191

VETERANS’ AFFAIRS OF NORTH DAKOTA
1411 – 32nd St. S.
Fargo, ND  58106-9003
1-701-239-7165

VOCATIONAL REHABILITATION
Administrative Office
Dacotah Foundation Building
600 South Second Street, Suite 1B
Bismarck, ND  58504
1-800-755-2745
1-701-328-8950
1-701-328-8968 (TTY)

Regional Human Service Center Offices
(See Directory: Human Service Center Offices, Regional)

WORKERS’ COMPENSATION BUREAU OF NORTH DAKOTA
500 East Front Avenue
Bismarck, ND  58504-5685
1-701-329-3800 (Voice)
1-701-328-3786 (TTY)