**Please refer to the Assistive Services Section of the STEPS Program Manual before submitting a request for assistive services.**

**\*\*All request packets must be submitted in full in order to be processed. Failure to provide all required information and documentation will result in an immediate denial.\*\***

**Date submitted:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Participant name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Community Services Coordinator:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MCO:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Requests for an assistive service must include the following:**

1. ***Justification for the assistive services being requested***  (Please check-off each task once complete)

Consumers must justify the need for assistive services. Letters of justification must include:

* A description of the equipment or modification\* requested
* A description of the problem or how the individual currently manages
* A description of how the assistive service will contribute to the participants health and safety as well as increase their ability to maintain employment and live independently

\*If submitting a request for a home modification, please note:

* FHAA reasonable accommodations/modification rights should be explored with the property owner/landlord
* You must remain at the modified property for at least 2 years
* Pictures and diagrams may be requested by the STEPS Program Manager

\*If submitting a for a vehicle modification, please indicate the following:

* Vehicle make and year
* Current mileage
* Ownership
* Whether the vehicle is completed paid for

1. ***Medical necessity for the assistive service***

A letter of medical necessity is required by the treating physician or other appropriate licensed professional in the area of expertise (a medical practitioner cannot establish medical necessity outside their area of expertise).

The letter should include the following:

* The medical condition for which the assistive service request is being made
* The functional limitations that result from the medical condition
* How the assistive service offers the most appropriate level of service
* How health and safety will be improved, resulting in the individual maintaining employment and independence
* Why this is the most cost-effective option when compared to alternative interventions

1. ***Bids for the assistive service***

A minimum of two (2) bids are required for an assistive service request. Please attach the bids to this form and include the provider’s contact information on this form. For home modifications, please be sure to include pictures and/or a construction diagram.

Please use this section to address any issues with getting a second bid:

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| --- |
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|  |

**Provider name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Provider contact phone # and/or email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. ***Other sources for payment***

Medicaid is the payor of last resort. Assistive service requests are only considered when other sources have been exhausted. Please document what other funding sources have been explored.

1. ***Assistive Service Provider***

Assistive services claims may only be submitted by providers of STEPS assistive services. Please indicate who will submit the claim for the approved assistive service.

***Medicaid Fraud and Abuse***

Providing fraudulent information when submitting a request for assistive services or selling items that were purchased with Medicaid funds is considered Medicaid fraud and abuse and will be reported to the Office of the Kansas Attorney General.

***MCO Responsibility***

It is the responsibility of the STEPS Program Manager to make the determination to approve or deny a request for assistive services within 20 business days of receiving a completed request packet. Once a determination has been made, the MCO is responsible for notifying the Community Services Coordinator, the participant, and any other applicable parties regarding the decision as well as submitting the authorization to the FMS provider for payment.

***Participant Statement of Agreement***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| I, |  | | , have reviewed and agreed to the | | | |
|  | Printed name of participant | |  | | | |
|  |  | |  | | | |
| Assistive Services Request and any/all accompanying documentation as submitted by: | | | | | | |
|  | | | | | |  |
|  | | | | | |  |
| Name of Community Service Coordinator | | | | | | |
|  | |  | | | | |
|  | | | |  |  | |
| Participant Signature | | | |  | Date | |