Community Based Alternatives

Rationale for Adaptive Aids, Medical Supplies, Dental Services and Minor Home Modifications

1. Applicant/Individual Name	2. Provider Vendor No.	3. Medicaid No.	4. Age

5. Specify the applicant's/individual's diagnosis/medical conditions and functional limitations:

Item 1

A. Specify the medical supply, adaptive aid, dental service or minor home modification requested:

B. Describe why the item/service is necessary and how the item/service benefits the applicant/individual in terms of treatment, rehabilitation or the ability to compensate for functional limitations:

Printed Name of Professional	Title/Agency	Area Code and Telephone No.

Signature – Professional	Date

Item 2

A. Specify the medical supply, adaptive aid, dental service or minor home modification requested:

B. Describe why the item/service is necessary and how the item/service benefits the applicant/individual in terms of treatment, rehabilitation or the ability to compensate for functional limitations:

Printed Name of Professional	Title/Agency	Area Code and Telephone No.

Signature – Professional	Date