



**Assistive Technology
Partnership**

Referral Form

- This form is only to be used by authorized representatives of the Aged & Disabled Waiver and Developmental Disabilities Programs
- When making a referral to the Assistive Technology Partnership, the information on this form is required.
- This form is fillable for print purposes only. This form can be completed and printed, however, this form cannot be submitted electronically and any information you add to this form cannot be saved.

Date	
Consumer	
Address	Phone
City/State/Zip Code	County
Medicaid ID #	
Date of birth	Disabling Condition
Age	
Person to contact (if other than consumer)	Phone
Aged and Disabled Waiver Eligible, receiving Aged and Disabled Waiver Services Eligible, receiving only Assistive Technology Service Ineligible Waiver, needs Funding Coordination	Developmental Disabilities Adult Services Developmental Disabilities Children Waiver
Program Eligibility Period	
Beginning Date	Ending Date
Consumer share of cost obligation. Please check : Yes No	
If Yes, how much?	
What assistance is being requested? (continue on the back as needed)	
Why is the assistance needed? (continue on the back as needed)	
Services Coordinator Name Address City/Zip Phone Fax E-mail address	Medicaid Eligibility Worker Name Address City/Zip Phone Fax E-mail address
Return this form to the Partnership office in your area: <ul style="list-style-type: none"> • Lincoln 3901 N. 27th Street, Suite 5, 68521 (402) 471-0734, Toll Free (888) 806-6287 Fax (402) 471-6052 • Kearney 315 W. 60th Street, Suite 300, 68845 (308) 865-5349, Toll Free (800) 683-6699 Fax (308) 865-5322 • Scottsbluff 505 A Broadway, Suite 500, 69361 (308) 632-1332 Fax (308) 632-1392 • Omaha 1313 Farnam on the Mall, 68102 (402) 595-1923, Toll Free (877) 201-4141 Fax (402) 595-1919 	