GRAC AAC Device Loaner Request

The Great River Autism Connection provides families and caregivers of individuals with Autism Spectrum Disorders a chance to learn, share, and gain resources. Our focus is on awareness, connection, and acceptance. One way we can support patients is by providing a loaner augmentative and alternative communication device, intended for short-term use with an agreement for a long-term strategy for a device. The patient must be evaluated by a Speech Therapist and the below steps must be taken prior to completing this application.

- ☐ Speech Therapist has an active order for communication difficulties from a doctor.
- ☐ Speech Therapist deems a communication device is necessary and tried multiple programs/options before completing paperwork for insurance.
- ☐ Primary Care Physician has completed Certificate of Medical Necessity/Prescription form.
- ☐ Speech Therapist submits report.
- ☐ Submitted to insurance.

After your application is reviewed, a GRAC committee member will give you a call within 10 business days to determine eligibility of providing a loaner AAC device. The purpose of this application is to support patients in the interim until the insurance approved device is available. If appropriate, a device will be loaned and tracked through GRAC members on a volunteer, but structured basis. The QMG Foundation reserves the right to loan the AAC Device to patients based on availability of device. The patient/parent (guardian) is held responsible for the replacement value of the device in the event of damage or loss. By signing below, you agree to terms of the GRAC AAC Device Loaner request. Please call the QMG Foundation at 217-222-6550 x6742 if you have any further questions.

Application for AAC Device Loaner – GRAC

Requested By & Job Title:

_____

Patient's Name:

_____

Parent/Guardian's Name:

_____

Patient's Address:

_____

Parent/Guardian's Contact Number:

_____

Loan Period Start Date:

_____

Loan Period End Date:

_____

Has process been started for permanent device purchase: Yes No

AAC Evaluation and Application Reviewed By:

_____

Approved: Yes No

I attest that the above information is accurate.

*A copy of the AAC evaluation report must be submitted/attached in order to qualify.

_____ _____

Patient Signature - Check here for patient verbal consent: ☐ Date

_____ _____

Quincy Medical Group Staff Signature Date

Request for Open Communication – Health Information

Quincy Medical Group and the QMG Foundation are committed to patient privacy. Information is released according to our Notice of Privacy Practices. This release only allows verbal communication. Written documentation will not be given out. In order for staff to speak with those you designate, this written permission form should be completed and returned to any staff member. Protected Health Information (PHI) must be specifically identified for release.

Patient Name: _____ Birthdate: _____

Address: _____ City: _____ State: _____ Zip: _____

By providing your signature, you indicate your consent to open communication with the QMG Foundation team & the GRAC committee. Please list any personal relationships that would be allowed to discuss your application with the QMG Foundation team and the GRAC committee.

Name	Relationship to you	Phone Number
Name	Relationship to you	Phone Number
Name	Relationship to you	Phone Number

I understand that there is no expiration date on this request. If at any time I wish to revoke this request, I must notify the QMG Foundation to complete a new form. I will be notified in writing if this request is denied. I understand that I can receive a copy of this form for my records if requested.
Please feel free to contact the office at 217-222-6550 x6742 with any questions.

Signature of Patient or Legal Representative Date