

AUGMENTATIVE ALTERNATIVE COMMUNICATION (AAC) EQUIPMENT  
SAFEGUARDING PLAN

Per PART He-W 575.06 9(b)(3) Prior Authorization: A completed Form #288-Q, "Quote for Augmentative and Alternative Communication (AAC) Aids Funding Request" (June 2014), completed and signed by a NH Medicaid DME provider.

A safeguarding plan outlines where the AAC equipment will typically be used, describes the steps that will be taken to keep the device safe and in good working order while in these locations, and identifies the person(s) responsible for keeping the device safe while at each location. Please complete this form for initial authorization and annually by October 31, and submit to the contact information at the bottom of this page.

MEDICAID RECIPIENT'S NAME \_\_\_\_\_ DEVICE: \_\_\_\_\_  
RECIPIENT MEDICAID ID #: \_\_\_\_\_

Location	A description of how the device will be kept safe while in this location	The name, title and phone number of person responsible for the device while it is at this location						
At the recipient's home								
While the devices is being transported to/from the home (e.g. on the bus)								
While the device is being transported within a location (e.g. at school, or within the community)								
In the classroom, at work or in a similar environment								
While mounted on the recipient's wheelchair (if applicable)								
<p>Signatures and contact information of person(s) responsible for downloading and synchronizing/backing-up software applications and programming, and install and update virus protection (if applicable), and coordinating this safeguarding plan:</p> <table><tr><td>_____ Signature and title</td><td>_____ Phone number</td><td>_____ Date</td></tr><tr><td>_____ Signature and title</td><td>_____ Phone number</td><td>_____ Date</td></tr></table>			_____ Signature and title	_____ Phone number	_____ Date	_____ Signature and title	_____ Phone number	_____ Date
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