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Assistive technology funding in the United States

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Abstract. The funding of assistive technology (AT) in the United States falls within a complex web of traditional and non-traditional funding sources that often create challenging barriers for individuals with disabilities. This article outlines the founding policies that drive the federal and state funding of AT across insurance, education, rehabilitation sectors and beyond. A presentation of specific medical and non-medical funding options is discussed addressing eligibility, types of AT covered and general program characteristics. I conclude with recommendations for the pursuit of AT funding in light of these policies and options.

Keywords: Assistive technology, funding, assistive technology policies, best practices

1. Introduction

Assistive technology can provide life-changing support for many people with disabilities, allowing improved functional performance and access to school, work and community opportunities taken for granted by the non-disabled. Among people with disabilities in the United States, however, an expanding gap exists between the need for AT and the availability of funding to acquire it. Despite the ever-increasing variety and capabilities of AT, along with the proliferation of information sources, device demonstration centers, and equipment evaluation opportunities, people with disabilities continue to struggle in finding available financial resources to acquire these liberating tools. All too often, the purchase of needed equipment must come from the individual's own pocket, creating a hardship on persons of middle and low income who are desperately in need of AT. Budget constraints at the federal, state and local levels contribute to this dilemma, leading to difficult choices for both governmental entities and the individuals they serve.

The purpose of this article is to provide a current and accurate representation of the state of assistive technology funding in the United States. Individuals with disabilities are often faced with the need for assistive technology and unaware of the funding streams and alternative options for successful funding. A concise summary of the diverse options available to individuals with disabilities in need may assist them, along with caregivers, service providers and policymakers, in making informed decisions. This article's focus on assistive technology funding from formative policy origins to individual strategies for success may provide a useful blueprint to both the consumer and practitioner. The article reviews the policy origins of AT provision and funding in the United States, including a discussion of traditional and non-traditional funding streams. These are presented across medical and non-medically directed sources and describe AT definitions, eligibility criteria and program characteristics. The concluding section offers recommendations for pursuing access to AT funding.

2. Policy origins in assistive technology

Braddock [1] describes the history of federal policy relating to disability as one that lacks coordination, with many conflicting approaches and incentives. Policies generally have not reflected practical concepts such as disability prevention, individual empowerment, and consumer choice, which are inherent principles in the implementation of AT solutions. The potential that AT holds for the individual with a disability is one of lowering or removing barriers that may exclude one from

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functional roles in society [2]. Physical environments may also be modified to create or increase inclusion by the person across school, work, home and play settings.

Many federal and state policies have been driven by the *medical model* which focuses on the physical, sensory, or cognitive status of the person considered disabled [3]. AT as perceived within an *independence model* looks at the individual as a whole and how AT and/or rehabilitative services can support a full and complete life. As laws in support of people with disabilities have evolved over the past century, this independence model has gradually come to the fore. At the same time, however, a complex maze of regulations, mandates and qualifications has made it difficult to figure out what funding options may be available to an individual person. The following section summarizes federal laws in the United States that address AT acquisition.

2.1. Vocational Rehabilitation Act of 1918

Beginning with the passage of the Vocational Rehabilitation Act of 1918 [4], the federal government established the first national program in the United States specifically directed to rehabilitation, focused on veterans with disabilities. An employment feasibility expectation was a fundamental requirement under the law. Necessary services and devices (AT) to achieve that employment outcome were included as approved components under the Act. This Act is significant in that it is the first public policy in the U.S. that legislated comprehensive funding for AT. It was limited by its veterans-only restriction and its required link to employment potential.

2.2. Smith-Fess act

This Act [5], passed in 1920, set the stage for future rehabilitative legislation by broadening funded vocational rehabilitation services to all disabled citizens, not just veterans. It provided funding for a prosthesis, for example, if it was considered necessary for completion of work-related training.

2.3. Vocational Rehabilitation Act Amendments

Amendments to the Vocational Rehabilitation Act occurred in 1943 [6], 1954 [7], and 1965 [8]. These amendments gradually expanded services to individuals with intellectual disabilities and other chronic disabling conditions and increased federal funding through state and federal matching grants. The expansion of eligible reimbursable services covered – including assistive and rehabilitative technology – was also an outcome.

2.4. Rehabilitation Act of 1973

This landmark legislation [9] expanded rehabilitation services to all eligible individuals through a coordinated comprehensive plan. It required "equality of opportunity through its provisions relating to consumer involvement, emphasis on persons with severe disabilities, creation of the National Institute on Handicapped Research, emphasis on program evaluation and the advancement of civil rights of persons with disabilities" [10].

2.5. Developmental Disabilities Assistance and Bill of Rights Act of 1975

This legislation [11] identified the individual with a disability as a *person* rather than *client* or *patient,* moving away from the medical model. It stressed that the individual should be viewed as a whole person rather than from an employment or medical perspective. It mandated that persons with developmental disabilities receive "services necessary to enable them to achieve their maximum potential" [12].

2.6. Education of the Handicapped Act of 1975, and Amendments of 1986, 1990, and 2004

This series of legislation [13–16], specifically identified provisions for the use of AT for students with disabilities. This was the first education law that allocated funding for assistive and special education technology. Under the Part H (Early Intervention for Infants, Toddlers and Families amendment) program, the use of assistive, orthotic and other related devices and services to promote the acquisition of functional skills is included. The 1986 amendments are commonly known as the Individuals with Disabilities Education Act (IDEA). Although the Technology Related Assistance Act (Tech Act) first defined AT devices and services, it was IDEA in 1990 that first outlined the public school district's responsibility to provide AT to students with disabilities. IDEA also included the Tech Act's definition of AT devices and services and a specific statement about the school district's role: "Each public agency shall ensure that AT devices or services or both, as those terms are defined are made available to a child with a disability if required as part of the child's special education, related services or supplemental aids and services." [14].

2.7. Rehabilitation Act Amendments of 1986

These amendments [17] required states to include their plans for rehabilitation engineering services in assisting individuals with disabilities throughout the rehabilitation process. This is the first definition of rehabilitation engineering in a direct relationship to AT as a range of services and devices which can supplement and enhance individual functions.

2.8. Technology Related Assistance Act of 1988, 1994, 1998, and 2004 Amendments

Among the broad purposes cited within this act [18–21] of particular note are the mandate to: "increase the availability of, funding for, access to, and provision of AT devices and services; increase the capacity of public agencies and private entities to provide and pay for assistive technology devices and assistive technology services on a statewide basis for individuals with disabilities of all ages; and increase the awareness of the needs of individuals with disabilities for assistive technology devices and for assistive technology services; identify Federal policies that facilitate payment for assistive technology devices and assistive technology services; identify Federal policies that impede such payment, and; eliminate inappropriate barriers to such payment. (PL 407 [2(b) (1)1]). The 1998 Re-Authorization of the Tech Act included a Title III which provided grants for Alternative Financing Programs to establish state loan financing programs for the purchase of AT. The 2004 amendments call for specific programs that will ensure direct access to technology. These may include AT loan programs, device demonstration programs, device reutilization programs, and alternative financing such as low-cost financial loan programs.

2.9. Americans with Disabilities Act of 1990

AT is addressed broadly throughout this civil rights act [22]. A strong emphasis is placed on "reasonable accommodations" in the workplace to allow the individual to perform job duties. Titles I and III include within the definition of reasonable accommodation the requirement that an employer provide necessary equipment, modification and purchase.

2.10. Rehabilitation Act Amendments of 1992 and 1998

These amendments [23,24], specifically refer to both the Americans with Disabilities Act and the Technology Related Assistance Act for definitions of AT, rehabilitation technology, and extended services. These amendments set a new course of policy for individuals with disabilities through terminology such as informed choice, self determination, integration, and full participation. This represents a further movement away from the traditional medical model to one of consumer direction and personal choice. Under this law, states must specify how their rehabilitation technology services will be delivered statewide, the training counselors will receive, and the manner in which AT will be provided. The 1998 amendments were significant primarily due to the streamlining of administrative procedures, expanding options for consumer choice, improving due process provisions, and increasing opportunities for consumers to obtain high quality employment. The Amendments also link the vocational rehabilitation (VR) program to a state's workforce development system. Additionally Congress amended the Rehabilitation Act to require Federal agencies to make their electronic and information technology accessible to people with disabilities under Section 508.

3. Medically directed funding sources for assistive technology

Many of the federally mandated sources for AT acquisition are driven by a medical model by which the consumer is viewed as a patient requiring medical services. The term most often used for this sort of AT is Durable Medical Equipment (DME). A medical professional must provide a justification that a physical deficit is present and that a medical necessity exists that will justify the DME. This model drives the funding for Medicaid, Medicare, and private insurance providers. It operates on the assumption that the person with a disability needs assistance for a particular area of impairment, rather than viewing the individual as a whole person seeking participation in everyday activities [25]. AT by nature can often fall outside the medical justification requirements of the medical model, which assumes a part of the person is broken and can be fixed. The medical model can limit the choices available within the Medicare/Medicaid system.

3.1. Medicaid

Medicaid is a state and federal funded insurance program for persons with limited income. Eligibility is

based on individual state requirements and is a vendor reimbursement program which makes payments directly to an individual's health care provider. A copayment may be required for some medical services depending on a state's requirements. Funding for AT is evaluated on a determination of medical necessity and the need for the durable medical equipment. Certain home and community based services for AT may be covered under Medicaid Waiver programs. Such items as medical supplies, equipment and appliances, physical therapy, occupational therapy, speech, hearing and language therapy, prosthetic devices, and preventative and rehabilitative services are covered services. The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a mandatory service under Medicaid which provides comprehensive AT to children up to age 21. All medically necessary diagnostic and treatment services within the federal definition of Medicaid medical assistance must be covered, regardless of whether or not such services are otherwise included under the state Medicaid plan for adults.

3.2. Medicare

Medicare is a federally-funded health insurance program for persons over 65, or those under 65 with either Lou Gehrig's disease (ALS) or kidney failure. Medicare has two programs which include a no cost mandatory hospital insurance (part A), and an optional medical insurance (part B). Part B allows enrollees to subscribe voluntarily to the program and requires a monthly premium, an annual deductible, and a 20 percent coinsurance rate. Benefits include coverage of partial costs for physician services; supplies and services incidental to a physician's care; outpatient or ambulatory medical, surgical or rehabilitative care; various outpatient ancillary services; for internal prosthetic devices, external braces, artificial limbs or eyes; and for rental or purchase of wheelchairs and durable medical equipment. Determination of medical necessity is central to the approval of AT by Medicare.

3.3. Private insurance

Private insurance is also a medical reimbursement program which provides funding for AT/durable medical equipment based upon the individual private provider's determinations of coverage. The entrance into the system begins with a physician's prescription. Determinations on what an insurance company will pay for are based upon its legal obligations as defined by an individual states' Insurance Commissioner unless the company is self-insured. The details of what is and is not allowable should be specified in the company's policy manual. Medical necessity is also central to their decision to approve needed equipment. Understanding the appeals process is essential to engaging the private insurance company when a funding request is denied.

3.4. Workers' compensation

Workers' Compensation is a financial support system established under law to provide income, medical care, and rehabilitation to employees for illness, injury, or death arising out of, and in the course of, their employment whether or not the employee was at fault [26]. The program exists in every state, and is funded through private insurance, state funds, or self-funding depending upon individual state regulations. Because of an employer's concern with the employee's productivity, rehabilitation activities and AT are often more quickly gained or realized through this system than through the Medicare/Medicaid system. Workers' Compensation benefits include cash benefits such as disability income payments for lost wages or lump sum payments for lost limbs, medical benefits and AT. These funds also support training in the use of any AT as well as vocational rehabilitation.

4. Non-medically and rehabilitation directed funding sources

Non-medically directed funding sources for AT are driven by the specific legislative and policy priorities established for the particular agency or organization. They are typically targeted to specific life roles, such as education, employment, or independent living. The AT must be justified and prescribed by one or more professionals for the purpose of providing meaningful assistance to accomplish specified program goals.

4.1. Public education

Students within the public education system in the U.S. can acquire AT through IDEA, which authorizes the provision of special education and related services to qualified students with disabilities. Related services are developmental, corrective and support services required to assist a student to benefit from education. They include, among other things, occupational and physical therapy, speech pathology, counseling and

health services. An AT device is one used to maintain or improve functional capabilities of a person with a disability; an AT service is one that assists in the selection, acquisition or use of an AT device. AT services include evaluations, adaptations, maintenance or repair of AT devices. AT services also include training or technical assistance for professionals, the individual or, where appropriate, the family [27]. The Individualized Education Plan Team determines the need for and inclusion of AT for the student. For students not in special education, Section 504 of the Rehabilitation Act [28] provides coverage for AT devices and services. Each public school is required to have a Section 504 plan in place.

4.2. Social Security

Disabled workers can access AT through a provision of the Social Security law. Benefits for persons with disabilities within the Social Security system are based on inability to work, specifically: A "medically determined physical or mental impairment" that "must have lasted or be expected to last for a continuous period of not less than 12 months." This disability must have prevented the person's engaging in substantial gainful activity for that same period of time. The Social Security Disability Income (SSDI) program provides income support and therefore indirect funding of AT. The Social Security Disabled Adult Child (SSDAC) program provides assistance to those who were disabled prior to age 22 and continue to be disabled in adulthood and who are or were dependent on someone who either receives Social Security or would have but that person is deceased. Working individuals with disabilities receiving SSDI and SSDAC have work incentives programs that are available and may be used for AT acquisition. A Plan for Achieving Self Support allows working and non-working individuals who have income other than Social Security Income to recoup up to 100% of the monthly cost of AT if it meets an occupational objective.

4.3. Vocational Rehabilitation

Adults with vocational potential may often access AT through state-managed Vocational Rehabilitation services. These programs require a recipient to be willing to pursue work and to have a disability that has been a major barrier to employment. AT and AT-related services may include assessment at each phase of the rehabilitation process, physical and restorative services, rehabilitation technology, including vehicular modifications, home modification, telecommunications, sensory, and other technological aides and devices. Computer equipment related to employment opportunities is considered AT.

4.4. Independent living

Though not AT providers, Centers for Independent Living (CILs) are mandated under the Rehabilitation Act Amendments of 1992 to provide advice and guidance on AT acquisition. CILs operate in every state of the Union, providing AT information and referral, independent living skills training, peer counseling and advocacy services. Eligibility requires the presence of a disability and the potential benefit from at least one of the above services. Many independent living services may include guidance on home modifications, AT devices that meet physical, sensory, or cognitive needs, transportation, or telecommunication aids.

4.5. Veterans Administration

The Veterans Administration (VA) is one of the largest purchasers of AT for persons with disabilities. These can include both medical and non-medical devices and may include automobile/van purchase or adapted housing/modifications for certain eligible veterans. Eligibility is based on honorable or general discharge from full time military service in one of the branches of the U.S. military. Not all veterans are fully eligible. The publication, Federal Benefits for Veterans and Dependents [29], summarizes the federal benefits available to veterans and their dependents. Veterans Administration medical centers in each state serve as the central point for AT evaluation, identification and provision for eligible veterans.

4.6. Alternative funding sources

Millions of people with disabilities who could benefit from AT cannot access it through any of the above-listed sources. For many, a low-interest loan may provide a solution. Alternative Loan Financing programs for AT have grown considerably over the last 15 years, in large part due to the Technology Related Assistance Act and targeted federal grants. The state Technology Act programs and the federal grants established under this legislation were critical in establishing the 33 loan programs for AT now operating nationally. They typically provide loans for vehicles and modifications, hear-

ing aids, mobility devices, and home modifications. A listing is located at the Rehabilitation Engineering and Assistive Technology Society of North America website [30]. These loan programs offer low interest loans for a variety of AT devices and services.

Community-based organizations serve as the local cornerstone for individuals seeking resources to acquire AT when traditional funding sources as described are not an option. These may include service organizations (i.e., Lions Clubs, Ruritans, Association for Retarded Citizens, Shriners, and more). These should be approached as a last resort for funding or to play a part in a blended funding strategy. National organizations that have state or regional chapters may be of assistance i.e., Alzheimer's, Multiple Dystrophy, Multiple Sclerosis Associations. When putting a funding request together to these organizations, documentation of unsuccessful funding attempts is important, and demonstration of the ability of the individual to contribute at least a part of the cost of the equipment is recommended.

5. Strategies for successful funding

As the previous section's description of multiple restricted sources shows, the process of securing funding for AT can be a daunting experience. It is important to recognize that the individual consumer is the best advocate, but enlisting the support of professionals who have AT acquisition experience can be advantageous. Knowledge is power and the deeper one's involvement, the better chance he/she has of finding resources. People who seek AT need to know their rights under the various applicable laws and prepare to defend any funding request and appeals if necessary. To maximize the possibility of success and minimize frustration, the following steps can assist in organizing an approach to successful funding [31]:

5.1. Define the need

Start by exploring options; know what you need and why you need it.

5.2. Document the need

Prove you need the AT by collecting information from professionals (i.e., occupational therapists, physical therapists, rehabilitation engineers, etc.) that document the functional benefits AT may provide. The documentation may include input from a combination of professionals, some or all of who may be willing to provide assistance throughout the request process.

5.3. Identify the device or service needed

Match your need with a specific device and/or service. Obtain written medical prescriptions or recommendations from professionals to substantiate the specific request. Find out prices of the device and service, and who can best provide it in your local area. As you look at prices and options, be aware of alternative devices and services that you could use. Knowing alternatives can give you options when negotiating with a recalcitrant funding source. Selecting the right technology is crucial if it is to be used successfully over the long term.

5.4. Determine if no or low cost alternatives are available

Before applying for funding, investigate alternatives and options. For example, would an adaptation to an activity suffice or could a needed device be borrowed from an AT loan closet or library managed by a school or state agency? Check to see if the same device or service is available at a lower cost. Also, determine if private insurance, a public agency or another third party payer will cover the cost.

If there are no alternatives, have the facts well documented to show all options have been explored prior to applying for funding.

5.5. Identify appropriate funding source(s)

Determine one or more likely sources of funding for the device. Don't limit your options. Keep a list of possible funding sources and decide where to start first. Get as much support and guidance as possible to ensure all funding options are identified.

5.6. Submit a request to the funding source

First, make contact with the funding source to determine what you need to do to submit a request. There is no one specific method to assure success. Try to get sufficient information on the process and required paperwork before submitting the request. It helps to find one person in the agency as a contact during the process. As you collect information and prepare the request, call your contact at the agency with questions and concerns. Making sure you understand now will save time and energy later. Keep a written record of all contacts with the agency. Complete the application and send in all the needed information with the request,

keeping copies of everything that is sent. Do not be surprised if a funding source asks for re-submission with additions and /or changes, particularly on a request for expensive items. Once the request is submitted and has met all the required criteria, wait for a determination. If notification of approval or denial of a request is not received within the indicated time frame, a courtesy call to the funding source may be advantageous.

5.7. Authorization is received

Once your request for funding has been approved, be sure to understand the exact amount of the authorization, along with the terms and processes for obtaining the requested device or service. Know if the funding source will purchase the device or provide the service directly or make arrangement with the vendor for the device or service. If the full amount of funding is not approved, go to your list of other options to supplement the amount awarded. Other possible options to supplement the approved funding include the AT loan financing program, personal or home equity loans, or community philanthropic organizations.

5.8. Appeal

If your request is denied, make contact with the funding source and determine through clear documentation why it was denied. If the denial was due to a lack of information or a misunderstanding, appeal the decision. Get information on the appeal process, particularly timelines and deadlines. Also determine legal options and processes and know when they may be appropriate to use.

5.9. Go to your next funding option

Don't give up. If you agree with the denial of your request continue with the next funding source. As we have seen, the search for AT funding is often mined with bureaucratic challenges that demand persistence, creativity and hard work.

6. Conclusion

Over the past century, the federal government has passed a series of laws aimed at making AT available to large segments of the disability population. These laws are complex and not comprehensive, however, so that the pursuit of AT can involve a dizzying maze of different sources, bureaucracies, technologies and service providers, each pathway made more complex by language that mandates eligibility guidelines, income requirements, medical necessity determinations and more. Negotiating this maze can be aided by the advice of rehabilitation professionals, consumer assistance boards, AT vendors and legally-mandated agencies. That said, a strong sense of personal advocacy and an unwillingness to accept an initial "no" as an answer can be the best tools for guidance through this complicated maze.

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