Form 6507
April 2004-E

Deaf-Blind Multiple Disabilities

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

Applicant/Individual Name	Provider Vendor Number	Medicaid Number	Age

Specify the Individual's Diagnosis/Medical Condition and Functional Limitations:

Item 1

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

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

Printed Name of Professional	Title	Telephone No. (inc.area code)

Signature of Professional	Date

Item 2

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

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

Printed Name of Professional	Title	Telephone No. (inc.area code)

Signature of Professional	Date