

# IMPACT

## Newsletter of the ASSISTIVE TECHNOLOGY Advocacy Project

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## CONSUMER RIGHTS IN THE MEDICAID PROGRAM The Due Process Protections Available to Recipients in the Prior Approval and Appeals Processes for Durable Medical Equipment

Technology has made astounding progress in the development of devices or equipment for people with disabilities. These devices can help achieve a level of function and independence never before available. For example, a standing feature for wheelchairs allows a person otherwise unable to stand to derive the medical benefits of passive and dynamic standing without the risks of transferring into a separate standing device. That same feature may enable the person to reach items in a cupboard, check food on a stove, and talk to friends on eye level.

As devices become more sophisticated, they may also become more expensive. Standing wheelchairs that liberate a person and immeasurably improve his or her quality of life, may cost more than \$35,000. Many people with disabilities would be unable to purchase a standing wheelchair without adequate funding.

Medicaid is one of the most significant funding sources for assistive technology (AT) for people with disabilities. Because adequate funding of AT is crucial to people with disabilities, it is important that consumers, their families, advocates, and service providers recognize that Medicaid recipients have important rights in the Medicaid funding process. This article will discuss consumers' rights, with the expectation that increased consumer empowerment will result in improved access to medically necessary AT or what Medicaid typically covers as durable medical equipment.

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## **Background: What is Due Process?**

When we speak about consumers' rights in this article, we are referring to due process. Due process is one of our most important rights, guaranteed by the Fifth and Fourteenth Amendments to the U.S. Constitution. It is on par with freedom of religion, freedom of speech, and freedom of the press, all protected by the original Bill of Rights. Yet, in our experience, due process is not well understood by the general public, despite its importance to the nation's Founding Fathers. What is due process?

### ***U.S. Constitution, Amendment V***

No person shall be . . . deprived of life, liberty, or property, without due process of law . . . .

### ***U.S. Constitution, Amendment XIV***

. . . nor shall any state deprive any person of life, liberty, or property, without due process of law . . . .

Neither the federal government (5<sup>th</sup> Amendment) nor state governments (14<sup>th</sup> Amendment) may deprive any person of life, liberty or property, without due process of law. Due process is a fundamental component of our judicial system.

Due process has been defined as an opportunity to be heard, to be aware that a matter is pending before a decision-making body and to make an informed choice about whether to acquiesce or contest. In its simplest terms, it is notice and opportunity to be heard and to defend in an orderly proceeding adapted to the nature of the case. Due process may be easiest to understand in the context of a criminal proceeding.

*Scenario #1: Joe has been arrested. Due process demands that he be told what charges are pending against him and entitles him to a speedy trial by an impartial jury. At trial, he has the right to assistance of counsel, to confront his accusers and adverse witnesses, and to present his own witnesses.*

How does due process work in civil cases?

*Scenario #2: Joe was treated at a hospital for injuries sustained while working. He received a bill but refuses to pay because he thinks Workers' Compensation should pay it. Also, Joe believes the bill is wrong because it lists services he does not think he received. Joe fears that the hospital will try to garnish his wages or put a lien on his house.*

*The hospital cannot take any of Joe's property, such as his income or his car, without due process. The hospital must sue Joe in court and serve him with sufficient notice of*

*the proceeding so that he can appear, confront adverse witnesses, and present his own evidence.*

Sufficient notice varies based on the type of proceeding. For example, a person seeking a divorce in New York must try to have the other party personally served. Sending the summons by mail is not sufficient and neither is telling the person about the action by telephone. In some instances, such as in Small Claims Court, sending notice by certified mail, return receipt requested, might be sufficient. Sufficient notice will vary depending on what is at stake. In each instance, however, Joe must receive adequate notice of the issues and the opportunity to present his side of the story in the appropriate forum, such as a court, before he can be deprived of his property.

In 1970, the U.S. Supreme Court decided, in *Goldberg v Kelly*, 397 U.S. 254, that public benefits, such as cash assistance, are property interests to those eligible to receive them. Therefore, an eligible person could not be deprived of public benefits without due process. The Court held that the evidence used to support the government's case had to be disclosed to the individual and the individual had to have an opportunity to present rebuttal evidence, including witnesses, any time benefits were to be terminated.

Cases following *Goldberg* have applied due process in the Medicaid context. Medicaid recipients have the right to due process, i.e., the right to adequate notice and opportunity to be heard any time the Medicaid agency terminates, suspends or reduces benefits, or denies an otherwise available service. These rights apply when a recipient is seeking prior approval for durable medical equipment (DME).

Federal Medicaid regulations set forth the specific content required in Medicaid notices and due process rights are captured in state laws and regulations. See 18 N.Y.C.R.R., Part 513. What does due process mean to the individual who seeks DME? To answer this, we must first discuss the procedure for obtaining Medicaid funding of DME. The recipient seeking DME must establish that the item sought meets the definition of DME and is medically necessary.

### **The Item Must Meet the Definition of DME**

Medicaid criteria requires that the equipment meet the definition of "durable medical equipment" in order to get Medicaid coverage. DME is defined as equipment which is:

- able to withstand repeated use;
- is primarily and customarily used for medical purposes;

- generally not useful to person in absence of illness or injury; and
- is not fitted or designed for a particular individual's use.

Where equipment is intended for use by only one person, it may be either custom-made or customized.

Whether an item meets the definition of DME can be a hotly contested issue. The Medicaid agency may be resistant to new or expensive equipment and may initially deny coverage, claiming the item is not DME. Scooters, therapeutic tricycles, and crib-like beds for adults and older children are examples of equipment the agency initially denied, claiming they are not DME. Denials of these items were successfully challenged at fair hearings, after which the agency was directed to approve funding.

The federal Centers for Medicare and Medicaid Services (CMS), which oversees Medicaid, distributed a policy letter in 1998 which stated that state Medicaid agencies are not permitted to maintain lists of items that are not covered (exclusionary lists), and must provide recipients an opportunity to prove that a requested item meets the DME definition.

We strongly suggest that advocates, medical providers and equipment providers review the particular item against the definition. Any time the agency categorically denies coverage of a specific item that appears to meet the definition of DME, the agency (i.e., the State Department of Health) may be wrongly maintaining an exclusionary list.

### **The Requested DME Must be Medically Necessary**

Section 365-a of the Social Services Law defines "medical assistance" as payment of part or all of the cost of medically necessary services or supplies which are necessary to prevent, diagnose, correct or cure conditions in the person that:

- cause acute suffering;
- endanger life;
- result in illness or infirmity;
- interfere with capacity for normal activity; or
- threaten to cause a significant handicap.

For example, Sally cannot walk to the kitchen without losing her breath, and cannot go shopping or to the doctor's because she lacks endurance. Sally cannot functionally ambulate and, therefore, has a condition which interferes with her capacity for normal activity. If Sally does not have enough energy to leave the apartment in an

emergency, she has a condition which endangers her life. Sally's doctor might decide that a wheelchair is medically necessary for her.

### **De-mystifying the Prior Approval Process**

The prior approval process starts when someone identifies a medical need and recognizes DME as a way of meeting the need. Sally may tell her doctor or physical therapist that she gets winded walking across the room. The therapist may contact an equipment provider to identify the right piece of equipment for Sally.

In order to get Medicaid funding, the item must be ordered by a practitioner (a doctor, physician's assistant, nurse practitioner, etc.) in the treatment of a specific medical condition. Then a vendor (retailer) approved by the Medicaid program must be located. If the item is a basic or standard item that appears on Medicaid's fee schedule, the vendor can submit for payment without prior approval. However, DME that is more customized or custom-made, usually the more expensive equipment, needs prior approval.

The vendor submits a prior approval application to the Department of Health (DOH), which is the Medicaid agency in New York State. The application must be accompanied by a letter of medical necessity from the treating or ordering practitioner. If the individual uses the services of a physical or occupational therapist or licensed speech pathologist, the therapist will often countersign the letter or write his or her own letter. The Medicaid agency has 21 days to act on the prior approval application. They can do several things: approve, deny, modify, or ask for additional information. If they ask the vendor for additional information, the 21 day time limit gets extended. The vendor must respond to any requests for information and often that means sending the request to the therapist or doctor, especially if the information sought is medical in nature. The ordering practitioner must cooperate with the DOH in its evaluation and take such actions as reasonably requested to assure proper and timely evaluation.

### **The Requested DME Must be the Least Costly, Equally Effective Alternative**

The vendor and ordering practitioner must make sure the requested DME is the least costly, equally medically effective equipment that would meet the individual needs. The letter of medical necessity must discuss other options reviewed and why they will not work as effectively. (See our Winter 2005-06 issue of *IMPACT*, with a lead article on Preparing Letters of Medical Justification, available at [www.nls.org/at/atwinter05.htm](http://www.nls.org/at/atwinter05.htm).)

## **Using Medicaid Coverage Categories Other Than DME to Fund Specialized Equipment**

There may be equipment that the Medicaid agency is unwilling to classify as DME, claiming it does not meet the four-part definition. For example, DOH may claim that medically-prescribed exercise equipment does not meet the DME definition because it is useful to individuals "in the absence of illness or injury." When this happens, we can look at several other Medicaid coverage categories as a way to fund a particular device.

**Orthotic and prosthetic devices.** Medicaid defines an orthotic as "appliances and devices used to support a weak or deformed body member; or to restrict or eliminate motion in a diseased or injured part of the body." Prosthetics are defined as "appliances and devices . . . which replace any missing part of the body." 18 N.Y.C.R.R. § 505.5. Some Medicaid agencies, outside of New York, were historically unwilling to classify a dual-purpose augmentative communication device (i.e., one that generates speech and functions as a personal computer) as DME, claiming it is useful in the absence of illness or injury. Without conceding on that point, advocates successfully argued that the dual purpose device met the prosthetic device definition as it replaced the functioning of the non-functioning speech organs.

**Physical therapy (PT) and occupational therapy (OT).** When therapy is prescribed by a physician or other licensed practitioner and is provided under the direction of a qualified PT or OT, this category includes any necessary supplies and equipment. If the exercise equipment, mentioned above, is medically prescribed as PT or OT, it can be funded by Medicaid even if it does not meet the DME definition.

**Services for speech, hearing and language disorders.** These are diagnostic, screening, preventative or corrective services provided by or under the direction of a speech pathologist or audiologist. This includes any necessary supplies or equipment. If the Medicaid agency was claiming that a particular augmentative communication or hearing device did not meet the DME definition, it could likely be funded under this speech-language category.

**Preventative services** are services provided by a licensed practitioner to prevent disability and its progression; prolong life and promote physical and mental health. A common preventative treatment for wheelchair users, to avoid decubitus ulcers, is daily whirlpool treatment. Some may argue that a home whirlpool unit is not DME because it is useful in the absence of illness or injury, but it certainly seems to fit as a preventive service. Similarly, a home whirlpool unit would seem to fit under the category of **rehabilitative services** - - which may include any medical or remedial services that reduce physical or mental disability - - if the individual already has decubitus and the whirlpool is prescribed to treat it and prevent it from getting worse.

**Early and Periodic, Screening, Diagnosis and Treatment (EPSDT).** EPSDT applies to all recipients under the age of 21, including young adults between the ages of 19 to 21 enrolled in Family Health Plus or Medicaid Managed Care. Under EPSDT, Medicaid must provide all other necessary health care, diagnostic services, treatment and other measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered by screening services. This category envisions a more proactive model of health care intervention for children that should result in both a broad range of equipment available to them and an expanded view of what is considered medically necessary. For instance, the federal Center for Medicare and Medicaid Services (CMS), in interpreting the scope of EPSDT coverage, has stated that "Medically prescribed exercise equipment, including exercise bikes, swing sets, tricycles and other assistive devices are also coverable benefits of the Medicaid program when determined to be medically necessary and cost effective." CMS Letter to Richard Allen, Medicaid Director (Colorado) March 7, 1996.

## **Obligations and Responsibilities of the Medicaid Agency**

The Department of Health's obligations in the prior approval process are set forth in state regulations. 18 N.Y.C.R.R., Part 513.

- The agency must assist the recipient in obtaining information and documentation in support of his or her request.
- The request must be determined in light of recipient's specific circumstances and recipient's functional capacity to make use of the equipment.
- The agency evaluation must be by a qualified professional and based on objective criteria.
- The agency must consider the opinions of the treating or ordering practitioner (i.e., doctor or other health care professional), all other information submitted by the recipient and all other available information.
- The agency must make all reasonable efforts to obtain needed information from the ordering practitioner before evaluating the information obtained from other sources or requesting a clinical examination.
- When the opinion is on matters within the expertise of the treating or ordering practitioner, it is entitled to great weight and cannot be outweighed solely by opinions of persons not of the same qualifications.
- If there is no clinical information or documentation conflicting with the opinion of the ordering or treating practitioner, the agency must approve the request as submitted.

### **The Medicaid Agency's Prior Approval Determination**

State regulations require that the agency's determinations:

- Be written, whether approving, denying or modifying.
- Contain certain information, such as the specific reasons for the determination, the right to request a fair hearing, and the right to a conference with the agency. It must also advise the recipient or applicant that he or she has 60 days to request a fair hearing, and that free legal services are available (such as the free services of our State AT Advocacy Project).
- Be sent to the applicant.

### **The Administrative Fair Hearing**

A fair hearing is an appeal of the agency's written determination. The recipient has the right to a hearing to challenge any adverse determination made by the Medicaid agency. A fair hearing

may also be requested to challenge any of the procedures the agency used to come to its determination, or if the agency failed to make a determination within specified time limits. Regulations provide that the hearing is to be held at a time and place convenient to the appellant (or individual appealing), as far as practicable.

Fair hearings are held before administrative law judges (ALJs) who must be impartial. A person may ask that the ALJ remove himself or herself from presiding at the fair hearing if the ALJ has:

- previously dealt in any way with the substance of the matter which is the subject of the hearing, except in the capacity as ALJ;
- any interest in the matter, financial or otherwise, direct or indirect, which would impair the independent judgment of the ALJ;
- displayed bias or partiality to any party to the hearing.

The ALJ is empowered to rule on the admissibility of evidence; regulate the course of the hearing; hear, review and evaluate the evidence; determine the credibility of witnesses and make findings of fact; and adjourn the fair hearing when, in the ALJ's judgment, it would be prejudicial to the due process rights of the parties to go forward on the scheduled date. The ALJ prepares an official report of what transpired at the hearing and makes a recommended decision.

Fair hearing records include a written transcript or recording of the testimony and exhibits, the ALJ's report and recommended decision, the final decision and all papers and requests filed prior to the close of the hearing. The appellant must have access to the record at a convenient time or place.

The agency prepares a summary and supporting packet, explaining why the prior approval request was denied or modified. These documents are submitted in advance of the fair hearing and the Medicaid agency typically asks that these documents be received in place of an appearance by a DOH representative. The applicant is entitled to a copy of the case summary before the hearing and should request one because it is crucial to prepare for the hearing. Remember that due process requires that the applicant have adequate notice of the Medicaid agency's case so that the applicant can attempt to refute the factual and legal basis of it.

The fair hearing is not intended as an opportunity for the agency to come up with new reasons to deny the application. As one court noted, "it is the notice of intent to discontinue which must state the reasons for the discontinuance..."

Those reasons must be detailed and specific.” *Ritzel v. Blum*, 81 A.D.2d 1029, 1030 (4<sup>th</sup> Dept. 1981). If the agency raises new reasons and the ALJ allows it, the ALJ should keep the record open to allow the appellant to respond or adjourn

### **Our AT Advocacy Project Has Successfully Appealed More Than Twenty Unfavorable Hearing Decisions**

As noted on this page, an unfavorable fair hearing decision can be appealed in state court through a process known as Article 78. During the past 12 years our State AT Advocacy Project has filed more than 20 such appeals. Nine of them have resulted in favorable court decisions, another seven or more were settled favorably before being heard by the court, and several are still pending.

Some of the court decisions have allowed individuals to obtain new or unique technology that Medicaid had initially denied.

See, e.g., *Sorrentino v. Novello*, 295 A.D.2d 945 (4<sup>th</sup> Dept. 2002)(approving standing device on power wheelchair, noting that the standing device would promote circulation, bone density, bladder and bowel function, prevent pressure sores, and prevent loss of muscle mass and muscle atrophy); *Ray v. Wing*, 238 A.D.2d 958 (4<sup>th</sup> Dept. 1997)(approving an Enduro Hemi-Height Wheelchair with custom seating, as petitioner established it would “prevent skin breakdown, decubitus ulcers and edema, . . . would provide better support and prevent back, shoulder and neck pain . . .”). *Id.* at 164. Similarly, we have often settled cases involving commonplace items that have not traditionally been viewed as durable medical equipment, including two cases in which Medicaid agreed to pay for portable ramps to allow a wheelchair user to enter and exit the home.

In some cases, the court decision or settlement serves to reinforce principles established in state regulations. See, e.g., *Layer v. Novello*, 17 A.D.2d 1123 (4<sup>th</sup> Dept. 2005)(in approving funding for a standing frame, the court held that the testimony of the physical therapist was entitled to significant weight and cannot be outweighed solely by the opinions of non-medical personnel or persons not in the same medical profession).

so the appellant has time to produce more information refuting the new reasons.

The fair hearing decision should be based only on the evidence submitted during the fair hearing, or afterward if the record was kept open for receiving additional information on a particular issue. Courts have held that due process is violated when the decision is based on a reason not given in the notice. *Matter of Simmons v. Van Alstyne*, 65 A.D.2d 869 (3<sup>rd</sup> Dept. 1978). The recipient must be provided adequate notice and an opportunity to be heard on each issue raised by the agency.

A fair hearing decision can reverse the agency decision and direct it to approve the device, remand to the agency for re-evaluation, or affirm the agency’s determination as correct. Both federal and state regulations mandate that the agency take final administrative action within 90 days of the date of the hearing request. This means the hearing should be scheduled and held, and the agency should comply with the decision within 90 days.

If the decision affirms and the applicant thinks the decision was either an incorrect application of the law and regulations or not supported by substantial evidence, the applicant can file a court proceeding pursuant to Article 78 of the CPLR, within four months from the decision date. (Note: An individual can also file a lawsuit in the U.S. District Court, in limited circumstances, to challenge a Medicaid agency’s fair hearing decision and/or other actions.)

Another option is to write a letter to the Principal ALJ to review and issue a new determination because the original decision was incorrect. It is also possible to re-submit the application.

### **Possible Due Process Violations**

In *Goldberg v. Kelly*, the Supreme Court noted that “the possibility for honest error or irritable misjudgment [on the part of the government agency] [is] too great” to permit termination of benefits without fully informing the recipient about the case against him and granting him an opportunity to contest and refute with evidence. The Court acknowledged then, that government agencies are not infallible.

In the same manner, the Medicaid agency may by honest error or irritable misjudgment violate the recipient’s due process rights. The right to due process should, in any context, be zealously safeguarded. There are a number of ways in which the recipient’s due process rights may be violated:

- The agency may fail to send the recipient a

## Due Process Violations Are Often Cited in Fair Hearing Decisions

The Department of Health's notice in *Becky K.*, FH# 4188380Q, advised the appellant that funding for a power wheelchair was denied due to lack of documentation to determine the medical necessity for this wheelchair. The notice cited only the general statutory provision, Social Services Law, section 365-a. The fair hearing decision, in remanding the case for further action, held that the notice of denial was not adequate because it failed to list the *specific* laws or regulations upon which the denial was based.

*Joseph G.*, FH# 4827393R, was denied funding for a full size Sleep Safe Bed, a type of adult crib. After hearing testimony and receiving evidence, the ALJ left the record open for the limited purpose of allowing the DOH to document the source of a statement that appeared in its summary. Instead, the agency submitted a lengthy addendum in which it raised new issues and provided new evidence. The decision directed the Medicaid agency to approve the bed, holding that to the degree that the addendum exceeded the limited purpose for keeping the record open, it infringed on the due process rights of the appellant and was not considered.

In *Brittany B.*, FH# 4575768R, the fair hearing decision directed the DOH to approve funding for a Monroe Bed, another type of adult crib. The Medicaid agency asked for a reconsideration, claiming, among other things, that it might consider approving the bed if the appellant's physician and family agreed to a monitoring plan. The Principle Administrative Law Judge rejected this point and affirmed the decision, noting that the agency had not raised a monitoring plan prior to the reconsideration and had not shown how the Monroe bed, by design, created a health/safety risk.

For copies of these decisions, call Marge Gustas at the AT Advocacy Project at 716-847-0650 ext 256.

written determination. This often happens when the agency rejects the request and/or sends it back to the vendor. A recipient "left out of the loop" does not know an appealable event occurred.

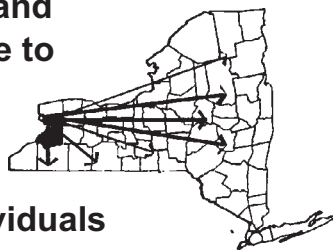
- The written determination may be legally insufficient. It may not explain the basis for the denial or modification in sufficient detail and may fail to advise the recipient about the right to a fair hearing.
- The notice may give one reason for the denial, yet the agency may submit evidence at the fair hearing regarding a very different reason. This deprives the recipient of adequate notice and the right to present evidence on the new issue. *See* fair hearing decision in *Joseph G.*, discussed in box on this page.
- The agency's packet of documents may not be complete. It may fail to include a document referenced in its summary.
- An *ex-parte* communication between the agency and the ALJ (i.e., a communication without the recipient or his representative present) deprives the recipient of the right to respond to any factual issues raised during those communications. The agency must send the recipient a copy of any documents it submits to the ALJ.
- The agency may submit post-hearing evidence not specifically allowed by the ALJ. *See* fair hearing decision of *Joseph G.*
- The agency may verbally advise vendors and therapists that certain equipment is not covered by Medicaid. If the vendor or therapist declines to request that equipment based on the agency's representations, the applicant has been deprived of the opportunity to challenge the agency's assertions through the fair hearing process.

### Conclusion

Due process was added to the Constitution to assure that people will not be deprived of life, liberty and property without adequate notice and opportunity to be heard. Knowing how this works in the Medicaid context, as enforced through Medicaid regulations, will help recipients navigate through the prior approval process, recognize when a fair hearing should be requested, and identify the issues that should be raised at the hearing.

Our New York State Assistive Technology Project is a project of Neighborhood Legal Services, Inc., a non-profit legal services office located in Buffalo, New York. As trained advocates, we assist people in a variety of AT-related funding issues, including Medicaid. Please feel free to contact us with specific questions, to refer a case to us, or to check on our availability to provide training on these issues.

The AT Advocacy Project provides statewide services: including limited advocacy services and technical assistance to advocates wanting to access funding for assistive technology for individuals with disabilities.



If you would like the *IMPACT* Newsletter sent to you in a large-print format or other alternative, please let us know.

We will be publishing *IMPACT* three times per year and we plan to discuss all of the primary assistive technology funding sources, including Medicaid, Medicare, special education programs, VESID, the Commission for the Blind, and private insurance programs. Please contact us if you have any special requests.

## Welcome to Neighborhood Legal Services' data bank!

Do you have decisions of interest relating to assistive technology in the following areas? Medicaid, Medicare, Vocational Rehab, VA, Special Education, Physically Handicapped Children's Program, Private Insurance, etc.

Other advocates can benefit from your experience. If you have fair hearing decisions or are involved in or have completed litigation in these areas, we want to know about it.

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The logo for IMPACT, with the word in a stylized, bold, italicized font.

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