

# **AAC Evaluation Referral Packet**

**Assistive Technology Services  
Advancing Opportunities**

**Please use this packet if requesting an  
Augmentative Communication Evaluation.**

- ◆ **Submit forms as described in the Checklist**  
(form entitled “1: AAC Evaluation Referral Packet: Checklist”)
- ◆ **Review responsibilities in the cover letter**

**Questions? Call Judy Nigl:  
888-322-1918, x595.**

# 1: AAC Evaluation Referral Packet: Checklist

Student Name:	District:	Date:
---------------	-----------	-------

Thank you for requesting an Augmentative Communication (AAC) Evaluation with Advancing Opportunities. Helping someone learn a new way to communicate is a complex and ongoing process. The following is a list of documents we need to complete the process as efficiently as possible.

**This entire packet must be completed** before the evaluation can be scheduled.

Please provide all requested information and return to:

Advancing Opportunities  
Attn: ATS Administrative Assistant  
1005 Whitehead Road Extension, Suite #1  
Ewing, NJ 08638  
(f) 609-882-4054

Please Send:

- Student Referral Form, with attachments
- 1. AAC Evaluation Referral Packet: Checklist (this form)
- 2. AAC Evaluation Questionnaires (SLP, OT, Teacher & Aide, and Parent)

What funding source will pay for the recommended equipment?

**Medicaid / Medicare / Private Insurance**

If Medicaid, Medicare, or private insurance are used, **we will send you a Medical Insurance Funding for Communication Device Packet.**

The written report we generate will describe **medical needs**; there can be no references to educational needs or the school district.

**Other Funding Source (i.e., school district)**

No additional forms are needed. The written report we generate will describe educational needs.

**Signature of Person(s) Completing This Form**

Name (print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Cerebral Palsy of New Jersey

To the Child Study Team Case Manager:

An augmentative communication evaluation is a team process. That means we do not do this alone—we need to work with the IEP team. Here’s an outline of what we will need to begin.

### Before the Evaluation

- Decide what you expect the student outcome to be for the evaluation**  
“What would you like to see the student do, that they cannot do now?”
- Identify related goals from the student’s IEP**

### **Step 1: Intake and Pre-Evaluation**

<b>Our Responsibilities</b>	<b>Your Responsibilities</b>
Background information is gathered from IEP team members	<input type="checkbox"/> Send all information described in the Checklist <b>(form 1)</b>
Evaluation is scheduled. Outline of Eval: <ul style="list-style-type: none"> <li>◆ Team Meeting: 30 minute meeting with IEP team</li> <li>◆ (if at the school) Observation: 15-30 min</li> <li>◆ Evaluation: 2 hours, with student, and at least 1 school staff person</li> <li>◆ Wrap-up: Meeting with at least yourself, to discuss findings and next steps.</li> </ul>	Arrange for team members to be available <ul style="list-style-type: none"> <li><input type="checkbox"/> For Team Meeting (parent, yourself, speech therapist, at least 1 teacher, and any other members who would be implementing recommendations)</li> <li><input type="checkbox"/> At least 1 staff person to work with us during the 2 hour evaluation. (person who will be most involved in implementing recommendations)</li> </ul>

### **Step 2: Day of the Evaluation**

<b>Our Responsibilities</b>	<b>Your Responsibilities</b>
As outlined above.	If at the school, arrange for rooms for: <ul style="list-style-type: none"> <li><input type="checkbox"/> Team meeting, and</li> <li><input type="checkbox"/> Evaluation itself</li> </ul>
<u>Wrap-up</u> : Device Trial Request Form is left with child study team case manager, or main contact person	<ul style="list-style-type: none"> <li><input type="checkbox"/> Decide whether you wish to approve recommended trial and technical assistance</li> <li><input type="checkbox"/> Return form to arrange for device trial</li> </ul>

### Step 3: Device Trial

After the evaluation, we will **recommend a communication system or device for the student to use on a trial basis**. A trial period (4 weeks) is necessary to determine whether or not the new system will be compatible with the person's needs.

(Note: Medicaid **requires** a trial period.)

Our Responsibilities	Your Responsibilities
<ul style="list-style-type: none"> <li>◆ Ship device by UPS to person indicated on the Device Trial Request Form</li> <li>◆ Provide Technical Assistance, if approved</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Arrange for staff to be released for technical assistance training during the trial period, and to spend time getting to know the device on their own.</li> </ul>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Measure performance of student during trial</li> </ul>
We will arrange for UPS to pick up the device	<ul style="list-style-type: none"> <li><input type="checkbox"/> Have device re-packaged and ready to be returned for the date indicated on the loan form.</li> </ul>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Communicate to us the results of the trial, and whether or not you want us to submit a request for funding to Medicaid/Medicare/Private Insurance.</li> </ul>

### Step 4: Submitting to Medicaid / Medicare / Private Insurance for Purchase of Device

If a medical funding source will be used to purchase the equipment, then we will write a report in medical terms, and perform the following functions.

Our Responsibilities
<ul style="list-style-type: none"> <li>◆ <b>Prescription with Doctor's Original Signature:</b> We will send a prescription (to be signed and returned to us), to the student's physician, documenting the medical need.</li> </ul>
<ul style="list-style-type: none"> <li>◆ <b>Assignment of Benefits form:</b> We will send the device vendor's Assignment of Benefits form to the student's family. This form must be sent back to us.</li> </ul>
<ul style="list-style-type: none"> <li>◆ <b>Submit Paperwork to Vendor:</b> To include: prescription, the device vendor's Client Information form, copy of the Medicaid card, and the report of our evaluation and trial).</li> </ul>
<ul style="list-style-type: none"> <li>◆ The report will be cc'd to the child study team case manager</li> </ul>

***Step 5: Implementing and Supporting AAC Device Use In Daily Life***

Obtaining a device is just the beginning. Once you've heard from the vendor that the device has been approved, then **please contact us** to begin the implementation phase.

Implementation begins with a written action plan that provides detailed information about how the AAC system will be used in specific educational settings, what training and support are needed, and who will do it.

# Student Referral for Assistive Technology Services To Advancing Opportunities

School District: \_\_\_\_\_

Date: \_\_\_\_\_

**- Please use black ink -**

**PO # is required:** \_\_\_\_\_

**Student** (One form per student, please. If service is not for a particular student, leave blank.)

<b>Name:</b>				<b>Grade:</b>		
<b>Parent/Guardian Name:</b>			<b>Relationship:</b>			
<b>Home Add:</b>						
<b>City:</b>		<b>State:</b> <u>NJ</u>		<b>Zip:</b>		<b>County:</b>
<b>Phone:</b>						
<b>E-Mail:</b>						
<b>DOB:</b>		<b>Gender:</b>		<b>Disability:</b>		

## Child Study Team Case Manager

<b>Name:</b>						
<b>Address:</b>						
<b>City:</b>		<b>State:</b> <u>NJ</u>		<b>Zip:</b>		
<b>Phone #:</b>			<b>Fax:</b>			
<b>E-Mail:</b>						
<b>Send Satisfaction Survey by:</b> <input type="checkbox"/> <b>E-Mail</b> <input type="checkbox"/> <b>Mail</b>						

## Service Requested (please choose **ONE** from each line)

<input type="checkbox"/> <b>Evaluation</b> (Eval Packet required)  Hands-on and on-site, we work with the IEP team to help determine what technology would support the student in meeting their goals,  _____ # Travel Hours	<input type="checkbox"/> <b>AT Consult</b> (Eval Packet required)  A consultation through web conferencing to assist IEP teams to understand their assistive technology choices.	<input type="checkbox"/> <b>Support/Training</b> (2 hour minimum per visit)  Also called "Technical Assistance;" can include assistance with set-up, training, integrating device use into classroom.  _____ # Service Hrs    _____ # Travel Hrs
<input type="radio"/> <b>Augmentative Communication (AAC)</b>  Low-tech and high-tech aids to communication using symbols (objects, photos, illustrations, words).	<input type="radio"/> <b>Assistive Technology (AT)</b>  All other evaluations, including computer access, technology to support reading and writing, educational accommodations, accessibility, etc.	

**What would you like to see the student do, that they cannot do now?**


<b>School:</b>			
	<input type="checkbox"/> <b>District School</b>	<input type="checkbox"/> <b>Out-of-District School</b>	
<b>Principal:</b>			
<b>Address:</b>			
<b>City:</b>	<b>State:</b> <u>NJ</u>	<b>Zip:</b>	
<b>Phone #:</b>			

**Key School Staff** (i.e., teacher, aide, therapists; people who would implement recommendations)

Title	Name	Phone #	E-mail
Special Ed Teacher			
Occupational Therapist			
Speech Therapist			

**Additional information we should know:**


**To make a referral:**

Step 1: Get authorization and PO for service from Director of Special Services;

Step 2: For Evaluations and Consults, mail current IEP, relevant reports, and an AT or AAC Eval or Consult Packet;

If you do not have an AT or AAC **Eval Packet**, please call 888-322-1918, x 595 or go to [www.assistivetechologycenter.org](http://www.assistivetechologycenter.org) and click on the "Referral Forms" menu on the left. Click on "All Forms Page."

Step 3: Complete this form and mail or fax it to:

Advancing Opportunities  
 Attn: ATS Administrative Assistant  
 1005 Whitehead Road Ext, **Suite #1**  
 Ewing, NJ 08638  
 (f) 609-882-4054

The child study team case manager will be contacted in order to gather further background information, confirm all the people involved, and schedule services.  
 If you have any questions, please give us a call: 888-322-1918, x595.

**For Advancing Opportunities Staff Only:**

<i>Primary Staff Contact:</i>		<i>Tracking #:</i>
<i>Service Type:</i>	<i>Service Subject:</i>	
<i>Service Location:</i>	<i>Source: <u>FFS-School</u></i>	

**2a. Augmentative Communication Evaluation Questionnaire**

Assistive Technology Services, Advancing Opportunities-**Please use black ink**

Student Name:	District:	Date:
Person Completing Form:		Phone Number:
Relationship to Student:		
E-mail:		

Directions: Please respond to relevant questions, and skip any questions that you do not have an answer to. Return Questionnaire to: Child Study Team Case Manager

Does the student demonstrate functional object use? Please describe.

  

Does the student demonstrate behaviors (positive and negative) that impact his/her performance? Please describe.

  

Does the student read or write? Please describe

Can the student understand:

<input type="checkbox"/> Single Words	<input type="checkbox"/> Phrases	
<input type="checkbox"/> One-step directions	<input type="checkbox"/> With gestures	<input type="checkbox"/> Without gestures
<input type="checkbox"/> Multiple-step directions	<input type="checkbox"/> With gestures	<input type="checkbox"/> Without gestures
<input type="checkbox"/> Does not appear to understand spoken words		

Can the student recognize (please specify):

Objects \_\_\_\_\_

Photographs \_\_\_\_\_

Picture Symbols \_\_\_\_\_

Tactile Symbols \_\_\_\_\_

Letters \_\_\_\_\_

Words \_\_\_\_\_

What other forms of Assistive Technology does the student currently use?

Are there any other students in the classroom that use AAC?

What activities/classes does the student enjoy?

What activities/classes does the student NOT enjoy?

What would you like to see the student do that he or she cannot presently do?



System type: \_\_\_\_\_  
Type of symbols: \_\_\_\_\_  
Number of symbols per page/overlay: \_\_\_\_\_  
Size of symbols: \_\_\_\_\_  
Access method: \_\_\_\_\_

Has any form of AAC been attempted previously?  Yes  No  
If so, please describe attempts and successes/failures

Does the student have any hearing difficulties: \_\_\_\_\_  
\_\_\_\_\_  
Does the student have any vision difficulties: \_\_\_\_\_  
\_\_\_\_\_  
Does the student have any motor difficulties: \_\_\_\_\_  
\_\_\_\_\_

What would you like to see the student do that he or she cannot presently do?

## 2c. Augmentative Communication Evaluation Questionnaire

Assistive Technology Services, Advancing Opportunities

(This section to be completed by: Occupational Therapist)-**Please use black ink**

Student Name:	District:	Date:
Therapist Name:		Phone Number:
E-mail:		
Therapy sessions per week: Group                    Individual                    Classroom		

**Directions:** Please respond to relevant questions, and skip any questions that you do not have an answer to. Return Questionnaire to: Child Study Team Case Manager

**Fine Motor Ability**

The student :

can use fingers to press small targets (ie, 1" square targets)

has trouble using fingers to press small targets

Describe:

has limited or no use of upper extremities

For these students, what part of the body do they have the best control over?  
 hand    arm    leg    foot    head    leg

Describe:

Accuracy and Fatigue of these movements?

**Mobility**

The student is  ambulatory    ambulatory w/mobility aide    uses wheeled mobility

Mobility Aide Make	Model	Will be replaced soon?

Wheelchair Users: Please describe positioning throughout the day.  
(especially times when student is in seating other than wheelchair)

**Additional Information**

What assistive technology, supports, or strategies have you already tried?

Please include any other important information about the student:

## 2d. Augmentative Communication Evaluation Questionnaire

Assistive Technology Services, Advancing Opportunities

(This section to be completed by: Parent/Guardian)-Please use black ink

Student Name:	District:	Date:
E-mail:		

**Directions:** Please respond to relevant questions, and skip any questions that you do not have an answer to. Return Questionnaire to: Child Study Team Case Manager

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Siblings Names & ages: \_\_\_\_\_

Language(s) spoken at home:  English  Other: \_\_\_\_\_

Besides immediate family members, whom else does your child frequently interact with:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How are your child's hearing and vision (please specify): \_\_\_\_\_

\_\_\_\_\_

Augmentative and Alternative Communication (AAC) is a way of helping people who do not speak or are difficult to understand to more effectively communicate. Examples of AAC are sign language, pictures, written language and voiced output devices.

How does your child communicate with you and other family members?

What forms of AAC has your child used:

Do you feel he/she was successful? \_\_\_\_\_ Yes \_\_\_\_\_ No

Why?

Does your child demonstrate frustration with communication? If so, how?

Does your child use any special equipment? If so, please specify:

What does your child enjoy doing? (Toys, games, movies, sports, favorite characters)

What would you like to see your child do that he or she cannot do now?

What else should we know about your child?



## Advancing Opportunities

All Disabilities. Many Services. One Agency.

---

### Cerebral Palsy of New Jersey

#### Consent for Release

I, \_\_\_\_\_, do hereby consent to permit Advancing Opportunities to make still or moving pictures of me and/or record my voice, distribute said likeness and make such use thereof as they desire for media coverage. I will also allow the publication of information about my past experiences and myself with Advancing Opportunities, in any articles, press releases or other forms of publicity or public information. I realize that in so consenting, I hereby release and discharge Advancing Opportunities their employees and volunteers from any liability claims or demands, in law or in equity, that I might have against any of them by reason of such photography, voice recording and information and subsequent use thereof.

Sign Name:

\_\_\_\_\_

Print Name:

\_\_\_\_\_

Date:

\_\_\_\_\_

---

Parent/Guardian Signature if the individual is a minor)

This document is valid for two years from the date of signature

# Medical Insurance Funding for Communication Device Packet

Assistive Technology Services, Advancing Opportunities

We have received your request for an Augmentative Communication Evaluation.

You are receiving this packet because you indicated that the student's family would be using their Medical Insurance (Medicaid / Medicare / Private Insurance) to pay for the recommended communication device.

◆ **Submit this information:**

- Copy of Medicaid / Medicare / and/or Insurance cards, **front and back***
- Client Information Form
- Consent for Release Form

**Questions? Call Judy Nigl:  
888-322-1918, x595.**

# Medical Insurance Funding for Communication Device: Client Information Form

Student Name:	District:	Date:
Student Social Security Number:		

**Client Information (Student)** The client is the person who will be receiving the equipment or services  
 Currently own a communication device?  Yes  No Make/Model: \_\_\_\_\_ Date of Purchase: \_\_\_\_\_

Current Place of Residence:

<input type="checkbox"/> Home	<input type="checkbox"/> Skilled Nursing Facility	<input type="checkbox"/> Intermediate Care / Mentally Retarded Facility
	<input type="checkbox"/> Nursing Facility	<input type="checkbox"/> Hospice Program
	<input type="checkbox"/> Assisted Living	<input type="checkbox"/> Inpatient Hospital
	<input type="checkbox"/> Group Home	

**Diagnosis** Student condition which requires requested equipment or services

Primary Diagnosis: \_\_\_\_\_ Date of Onset: \_\_\_\_\_

Secondary Diagnosis: \_\_\_\_\_ Date of Onset: \_\_\_\_\_

Is Diagnosis a result of an accident?  Yes  No If yes: Date of accident? \_\_\_\_\_

Type of Accident?  Employment  Auto If Auto: Place (state)? \_\_\_\_\_

**Treating Physician** The treating physician is the medical doctor who has prescribed the requested equipment

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Phone: (     ) -     Alternate Phone: (     ) -     Fax: (     ) -    

### Funding Sources

Mark which types of coverage the Student has. **Please attach copies of current insurance cards (both front and back) to this form.**

#### Primary Insurance

Type:  Medicare  Medicaid  CHAMPUS / Military Coverage  Private/Group  HMO

If Primary Insurance is Medicare or Medicaid, just fill in the ID number below and proceed to Secondary Insurance.

Name of Insurance: \_\_\_\_\_ ID Number: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Contact Phone: (     ) -     Contact Fax: (     ) -    

Billing Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Policy Holder / Insured**

Name: \_\_\_\_\_ Phone: (     )     -     Fax: (     )     -

Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_ Social Security Number:     -     -

Relationship to Student:  Parent    Legal Guardian    Spouse    Other     Date of Birth: \_\_\_\_\_

---

**Secondary Insurance**

Type:  Medicare    Medicaid    CHAMPUS / Military Coverage    Private/Group    HMO

If Primary Insurance is **Medicare** or **Medicaid**, just fill in the **ID number** below and proceed to Treating Physician.

Name of Insurance: \_\_\_\_\_ ID Number: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Contact Phone: (     )     -     Contact Fax: (     )     -

Billing Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Policy Holder / Insured**

Name: \_\_\_\_\_ Phone: (     )     -     Fax: (     )     -

Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_ Social Security Number:     -     -

Relationship to Student:  Parent    Legal Guardian    Spouse    Other     Date of Birth: \_\_\_\_\_

---

**Signature of Person(s) Completing This Form**

I verify that all information contained in this form is correct and true to the best of my knowledge.

Name (print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_