

AT Evaluation Referral Packet

**Assistive Technology Services
Advancing Opportunities**

**Please use this packet if requesting an
Assistive Technology Evaluation.**

- ◆ **Submit these forms:**
 - Student Referral form, with attachments
 - AT Evaluation Questionnaires
(Teacher & Aide, OT, and Parent)

- ◆ **Review responsibilities in the cover letter**

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

Cerebral Palsy of New Jersey

To the Child Study Team Case Manager:

Assistive Technology evaluations are 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

Our Responsibilities	Your Responsibilities
Background information is gathered from IEP team members	Send: <ul style="list-style-type: none"> <input type="checkbox"/> Student Referral form, with attachments <input type="checkbox"/> AT Evaluation Questionnaires (Parent, Teacher & Aide, OT)
Evaluation is scheduled. Outline of Eval: <ul style="list-style-type: none"> ◆ <u>Team Meeting</u>: 30 minute meeting with IEP team ◆ <u>Observation</u>: 15-30 minutes, in class ◆ <u>Evaluation</u>: 2 hours, with student, and at least 1 school staff person ◆ <u>Wrap-up</u>: Meeting with at least yourself, to discuss findings and next steps. 	Arrange for team members to be available <ul style="list-style-type: none"> <input type="checkbox"/> For Team Meeting (parent, yourself, speech therapist, at least 1 teacher, and any other members who would be implementing recommendations) <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)

Step 2: Day of the Evaluation

Our Responsibilities	Your Responsibilities
As outlined above.	Arrange for rooms for: <ul style="list-style-type: none"> <input type="checkbox"/> Team meeting, and <input type="checkbox"/> Evaluation itself (can be same room)

Step 3: After the Evaluation

Our Responsibilities	Your Responsibilities
Our report will be sent to you within 2 weeks.	<ul style="list-style-type: none"><li data-bbox="870 346 1430 449"><input type="checkbox"/> Decide whether you wish to approve recommended assistive technology and technical assistance<li data-bbox="870 470 1430 573"><input type="checkbox"/> Return Student Referral form to arrange for technical assistance and begin the implementation process

Next Steps: Implementing and Supporting Assistive Technology in the Classroom

Obtaining the assistive technology is just the beginning. Once you've made the decision to order the assistive technology, then **please contact us** to begin the implementation phase.

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

If you have any questions, please don't hesitate to give me a call: 888-322-1918, x595, or e-mail me: jnigl@advopps.org.

Sincerely,

Judy Nigl
Administrative Assistant
Assistive Technology Services

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.)

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

Child Study Team Case Manager

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

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

<input type="checkbox"/> Evaluation (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"/> AT Consult (Eval Packet required) A consultation through web conferencing to assist IEP teams to understand their assistive technology choices.	<input type="checkbox"/> Support/Training (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"/> Augmentative Communication (AAC) Low-tech and high-tech aids to communication using symbols (objects, photos, illustrations, words).	<input type="radio"/> Assistive Technology (AT) 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?

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

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 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>	

Assistive Technology Questionnaire

Assistive Technology Services, Advancing Opportunities

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

Student Name:	District:	Date:
Parent / Guardian Name:		
E-mail:		
Sibling Names:	Age	

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

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

Definition of Assistive Technology: "Any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve functional capabilities of individuals with disabilities."

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

What are your child's interests?

Sports	Music
Book	Magazines
Pets	Television
Games	Others:

What type of computer equipment is available at home?

Microsoft XP 7 Not sure

Macintosh OS10 OS 10 Other Not Sure

Computer is ____ years old.

Who is responsible for technical support for the family computer?
Where is the computer located in the home?

What does your child use the computer for?

Homework: 1-2 times a week 3-4 times a week Daily

Games: 1-2 times a week 3-4 times a week Daily

Internet / Email: 1-2 times a week 3-4 times a week Daily

Social Networking: 1-2 times a week 3-4 times a week Daily

Please include any other important fact that you would like to share about your child:
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Assistive Technology 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 Days: <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday		

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

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

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

Vision

Does the student use Glasses? Contacts?

Does the student have vision issues that affect access to learning materials?
(i.e.: computer, books, handouts, blackboard)

Mobility

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

Please list any mobility aids used:

Mechanics of Writing

What tasks are difficult for the student? Please **rank** these in order of importance.

	Legibility
	Speed of Writing
	Fatigue
	Other:

Computer Skills

<input type="checkbox"/> Uses standard keyboard	<input type="checkbox"/> Does not work on keyboarding skills
<input type="checkbox"/> Alternative Keyboard: _____	
<input type="checkbox"/> Uses standard computer mouse	<input type="checkbox"/> Does not work on mouse skills
<input type="checkbox"/> Alternative Mouse: _____	
Can read information from the computer screen? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Typing Skills / Speed

<input type="checkbox"/> Does not currently type	<input type="checkbox"/> Activates desired keys on command
<input type="checkbox"/> Types slowly, with one finger	<input type="checkbox"/> Types slowly, with more than one finger
<input type="checkbox"/> Performs 10 finger typing	<input type="checkbox"/> Accidentally hits unwanted keys
<input type="checkbox"/> Requires arm or wrist support to type	

Additional Information

Please include any other important information about the student:

Assistive Technology Questionnaire

Assistive Technology Services, Advancing Opportunities-**Please use black ink**
 This section is to be completed by **each** of the student's teachers and educational aides

Student Name:	District:	Date:
Person Completing Form:		Grade:
Subject:	Room Number:	
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

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

What supports / accommodations are already in place to help the student overcome identified difficulties?

Accommodation	Task (ie, note taking, short answers, homework)	how effective has this been, and why?

Classroom Information

How many computers are available in the classroom for the student to use? _____

What types of computers are in the classroom? PC MAC

Does the student need to login under own name? Yes No

Does the student have access to the computer during class time? Yes No

Do any of the classroom computers have specialized software programs?

- Write Out:loud Intellitalk Microsoft Office (Word, Excel, PowerPoint)
- Co:Writer Inspiration Kuzweil
- Draft Builder Kidspiration WYNN
- Other: _____

Computer Skills

- Uses standard keyboard Independently Need Assistance N/A
- Uses a standard computer mouse Independently Need Assistance N/A
- Reads from the computer screen Independently Need Assistance N/A
- Open a document Independently Need Assistance N/A
- Can name a document Independently Need Assistance N/A
- Use Spell check Independently Need Assistance N/A
- Navigate the Internet Independently Need Assistance N/A

Reading and Writing

What tasks are difficult for the student? Please rank these in order of importance.

Rank	<input type="checkbox"/> Mechanics of Writing	Rank	<input type="checkbox"/> Composing Written Material
	Legibility:		Idea of Organization / Pre Writing:
	Speed:		Proof Reading:
	Fatigue:		Spelling:
	Other:		Other:

Rank	<input type="checkbox"/> Reading Skills	Rank	<input type="checkbox"/> Other
	Decoding:		Organizational Skills:
	Comprehension:		Daily Living / Life Skills:
	Speed:		Note Taking:
	Other:		Other:

Are math skills an area of difficulty for the student? Yes No

Math Subject
Specify Math Program:
Grade level:
Describe students difficulties:

Please include any other important information about the student:



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