

Student Referral for Assistive Technology Services To Advancing Opportunities

School District: _____ Date: _____
 This request has been approved by the Director of Special Services (or authorized signer), based on contract with Advancing Opportunities, effective from _____ to _____.

Signature or initials: _____ **PO # is required:** _____

-Please use black ink-

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:
Home Phone:						
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 Evaluation OR Support/Training)

<input type="checkbox"/> Evaluation (<i>select AAC or AT</i>) <ul style="list-style-type: none"> <input type="radio"/> Augmentative Communication (AAC) (Completed AAC Evaluation Referral Packet <u>must</u> be returned prior to scheduling.) low-tech and high-tech aids to communication using symbols (objects, photos, illustrations, words) with or without voice output. Or <input type="radio"/> Assistive Technology (AT) (Completed AT Evaluation Referral Packet <u>must</u> be returned prior to scheduling.) all other evaluations, including computer access (alt to standard keyboards and mice), technology to support reading and writing, educational accomm., accessibility, etc. 	<input type="checkbox"/> Support/Training 2 hour minimum per visit (called "Technical Assistance;" can include assistance with set-up, training, integrating device use into classroom) <ul style="list-style-type: none"> <input type="radio"/> Augmentative Communication Or <input type="radio"/> Assistive Technology _____ # Hours Requested (Or ___ Please contact me to discuss number of hours needed)
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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 for service from Director of Special Services;

Step 2: For Evaluations, mail PO, current IEP, relevant reports, and an AT or AAC Evaluation Referral Packet;

If you do not have an AT or AAC **Evaluation Referral 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 Extension
 Suite #1
 Ewing, NJ 08638
 (f) 609-882-4054

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

Primary Staff Contact:		Tracking #:
Service Type:	Service Subject:	

Service Location:

Source: FFS-School