

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:
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 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) (AAC Evaluation Packet <i>must</i> be returned) low-tech and high-tech aids to communication using symbols (objects, photos, illustrations, words) Or <input type="radio"/> Assistive Technology (AT) (AT Evaluation Packet <i>must</i> be returned) all other evaluations, including computer access, technology to support reading and writing, educational accomm., accessibility, etc. _____ # Travel Hours 	<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 _____ # Service Hours _____ # Travel Hours
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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 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>	