

# *Assistive Technology Equipment Assessment*

Computers  
Augmentative Communication  
Access



Bonnie Brown, Superintendent, District 75

June 2006

District 75  
400 First Avenue  
New York, NY 10010

### **Acknowledgements**

This Assistive Technology Equipment Assessment (ATEA) is based on various materials, tests, research, and hands on experience. The packets for teachers, speech therapists, occupational therapists, physical therapist and parents were part of the original evaluation process for Augmentative/Alternative Communication (AAC) for District 75, New York City Board of Education. The original process for the AAC evaluation was based on materials from the Communication System Evaluation Center, Orlando, Florida, and the Pennsylvania Assistive Device Center, Harrisburg, Pennsylvania.

Additional materials have been added to make the assessment more current and to meet needs of all assistive technology areas-computers, access, and switches. Recommendations for equipment and training have also been included.

Information and materials from Assistive Technology Center (ATC) Coordinators, and Office of Related and Contractual Services (ORCS) have contributed to this assessment.

In addition, we would like to acknowledge the committee who assisted in developing the original ATEA package:

Barbara Weiner, Evaluation Coordinator Technology Solutions;

Helen D. Kaufman, Director Citywide Speech Services;

and the following speech therapists from various Citywide schools and programs:

Gale Alessandroni; Jeri Carter; Sora Goodman; Caryn Hager; Audry Haimowitz; Diane Mastro; Karen Papowsky; Marlene Prager; Anne Sweeney Meade

# **Guidelines for Referral and Candidacy for Students in Need of Assistive Technology**

## **ATEA**

ATEA refers to the Assistive Technology Equipment Assessment packet. The ATEA packet is comprised of many forms. It is approved by District 75 and New York State for the purpose of having students evaluated for assistive technology.

**This packet serves a dual purpose.** It may be used:

1. as the evaluation tool to be used by schools to perform their own assessments; or
2. as a basis to refer a student for evaluation by the District 75-based Technology Solutions team.

Below you will find a description of the different forms of the ATEA that must be completed for either a referral to Technology Solutions or a school-based assessment. Each form can be downloaded from the District 75 website.

## **School-based Evaluation**

District 75 schools can perform their own AT evaluations as long as they adhere to the following guidelines:

- They demonstrate knowledge and experience with using AT;
- They have access to equipment to use during the assessment; and
- They are able to work as a team that consists of 3+ members working on a daily basis with the student. Team members can include classroom teacher, paraprofessional, parent, speech therapist, OT, PT, vision or hearing teacher, etc.

## **School-based team will need to fill out the following forms**

1. student identifying information
2. background information
3. switch evaluation (if appropriate)
4. equipment evaluation AAC (if appropriate)
5. equipment evaluation computer (if appropriate)
6. equipment recommendations
7. goals
8. the appropriate packet for each of the team members (teacher, speech teacher, OT, PT, and parent). Other team members can write up their own narratives.

## **Schools must also include:**

1. a copy of the most recent IEP
2. a cover letter explaining that the completed packet needs to go to Technology Solutions for approval.

**This entire packet must be submitted to the school-based support team or the IEP review team at the school.** The evaluation team will generate a type-3 form. The SBST must keep a copy of the entire packet and send the original to Technology Solutions for approval. Concurrently, the SBST should enter the request for evaluation into the CAP system.

**Upon receipt of an approval letter from Technology Solutions** the SBST will enter the results for the evaluation into the CAP system and follow the instructions provided for adding AT to the IEP.

In the event that the recommendation is not approved by Technology Solutions, a letter of explanation and instructions will be provided.

### **District-based Technology Solutions Team Evaluation**

In the event that the school feels that the student would be better served by having Technology Solutions perform the evaluation, they will then need to **complete the following forms**

1. student identifying information
2. background information
3. the appropriate packet for each of the team members (teacher, speech teacher, OT, PT, and parent). Other team members can write up their own narratives.

**Schools must also include:**

1. a copy of the most recent IEP
2. a cover letter requesting the Technology Solutions team perform the evaluation

**This entire packet must be submitted to the school-based support team or the IEP review team at the school.** The school will generate a type-3 form. The SBST must keep a copy of the entire packet and send the original to Technology Solutions to perform the evaluation. Concurrently, the SBST should enter the request for evaluation into the CAP system.

**Upon receipt of the completed evaluation and results from Technology Solutions** the SBST will enter the results for the evaluation into the CAP system and follow the instructions provided for adding AT to the IEP.

# **Determining Candidacy for an AT Evaluation**

## **Computer/Computer Access**

Typical candidates for a computer and/or computer adaptations are those students who due to their physical and/or cognitive limitations:

- cannot write, or cannot write legibly, or
- it has been sufficiently demonstrated that computer access will provide functional writing speed that cannot otherwise be achieved.

It is expected that these students will need the power of a personal computer to complete their academic work. Certain students may only require access to a computer that is already in the school or classroom. For these students adaptive computer access may be obtained (e.g., expanded keyboards, keyguards, etc.) Generally, personal computers will not be purchased solely for the purpose of computer based educational instruction.

## **Alternative Access**

Typical candidates for alternative access are students who demonstrate an inability to access computer technology or communication devices through traditional methods. This is generally due to a physical disability. Students may be evaluated for either programmatically-available devices or IEP-mandated equipment.

## **Augmentative Alternative Communication (AAC)**

Typical candidates for augmentative communication systems are students who demonstrate a greater understanding of language than they are able to express due to severe oral-motor dysfunction or structural damage of the speech mechanism. These students may exhibit:

- no functional speech or
- speech that is generally unintelligible

It is expected that these students will need an augmentative communication device to express their needs, and to take the place of, or add to, their verbalizations.

## **Vision Devices**

Typical candidates are students whose visual impairments are severe enough to affect their ability to access the computer screen beyond built in modifications available in the operating system or application. Additionally, the student must show a strong understanding of how to use the computer and have good keyboarding skills.

Notetaking devices and magnification systems are also available to students who demonstrate both the need and the appropriate aptitude.

## **Enabling Devices for Deaf/Hard of Hearing**

Typical candidates are students whose hearing impairments are severe enough to affect their ability to participate in the classroom. The technology may support students whose primary communication modality is lip-reading. Captioning devices are also available to students who demonstrate both the need and the appropriate aptitude.

### **The Team Approach**

In order to make a responsible decision as to appropriate equipment it is important that input is received from each team member working with the student. All team members should be involved in the decision-making process and should be available when the assistive technology evaluation takes place. It is recommended that prior to the evaluation, a team meeting be held to consider the following questions and fill out the referral form (ATEA).

- 1) Are all team members aware that assistive technology is being considered to benefit the student in his/her educational program?
- 2) Has the possibility of using assistive technologies been discussed with the student and family?
- 3) What kind of computers and/or augmentative communication devices are currently being used in the school?
- 4) Does the student have positioning needs that will be addressed prior to the evaluation or during the evaluation?
- 5) Who will be responsible for learning the day to day operation, setting up and securing of equipment?
- 6) Who will be responsible for making sure the equipment goes with the student if he/she changes classroom, school or program?
- 7) Who will work with the student on a daily basis until independent use is accomplished?
1. What are the specific educational goals that can only be accomplished through the use of assistive technology?

**If there are any additional concerns or questions please do not hesitate to call Technology Solutions, Karen Gorman, 212-802-1530.**

District 75  
400 First Avenue  
New York, NY 10010

**Assistive Technology Equipment Assessment/D75**

**IDENTIFYING INFORMATION**

Student Name: \_\_\_\_\_ Evaluation Date: \_\_\_/\_\_\_/\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ OSIS #: \_\_\_\_\_ CSE Case #: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Primary Language: \_\_\_\_\_

**Parent/Guardian Address:** \_\_\_\_\_ Telephone: \_\_\_\_\_  
 \_\_\_\_\_ Home: ( \_\_\_ ) \_\_\_\_\_  
 \_\_\_\_\_ Work: ( \_\_\_ ) \_\_\_\_\_

School/Site: \_\_\_\_\_ Program: \_\_\_\_\_ Service District: \_\_\_75\_\_\_

**School Address:** \_\_\_\_\_ Principal: \_\_\_\_\_

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

Evaluation Contact Person: \_\_\_\_\_ Title: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 \_\_\_\_\_ ( \_\_\_ ) \_\_\_\_\_

**Team Members / Service Providers**

<i>Teacher</i>			
<i>Paraprofessional</i>	Frequency	Duration	Group Size
<i>Speech &amp; Language</i>			
<i>Physical Therapy</i>			
<i>Occupational Therapy</i>			
<i>Vision Services</i>			
<i>Hearing Services</i>			
<i>Counseling</i>			
<i>Other</i>			

**Reason For Evaluation**

*Augmentative Communication* \_\_\_\_\_ *Computer/Computer Access* \_\_\_\_\_  
*Vision* \_\_\_\_\_ *Other-please indicate* \_\_\_\_\_

**BACKGROUND INFORMATION**

Student Name: \_\_\_\_\_ OSIS #: \_\_\_\_\_

A. List Adaptive/Assistive and Augmentative Communication Equipment available at school:

\_\_\_\_\_  
\_\_\_\_\_

B. Student's experience with above equipment

\_\_\_\_\_  
\_\_\_\_\_

• Type of computer(s) in school / home:

\_\_\_\_\_  
\_\_\_\_\_

• Please list type of software used:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

C. Will student be moving from class to class? \_\_\_\_\_

D. Description of handwriting skills: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

E. Describe any Physical/Sensory/Perceptual deficits which interfere with accessing a computer or augmentative communication system:

\_\_\_\_\_  
\_\_\_\_\_

G. Size of print/symbol student is able to read/identify: \_\_\_\_\_

**SWITCH EVALUATION**

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

OSIS #: \_\_\_\_\_

Examiner / Title: \_\_\_\_\_

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

*Please answer the following questions based on 5 trials.*

QUESTIONS	BODY PARTS							
	<i>HAND</i>	<i>ARM</i>	<i>LEG</i>	<i>FOOT</i>	<i>HEAD</i>	<i>CHIN</i>	<i>FACE</i>	<i>OTHER</i>
Specific body parts activating switch								
Type of switch:								
Location of switch								
Movement used to activate								
Turns switch on								
Turns switch off								
Turns switch on upon request								
Turn switch off upon request								
Can activate switch without looking for it								
Can activate switch for specific number of times and stop (Manual Scan)								
Turns switch on when presented with a prompt (Automatic Scan)								
Holds switch on for long and short periods (Morse Code)								
Does the student like the movement?								
Does the student like the switch?								
Is there minimal fatigue/tiring?								
Does the switch interfere with function?								
Are the same results obtained at a later date?								

Use this form ONLY for school-based assessments.

**EQUIPMENT EVALUATION - AAC**

Student Name: \_\_\_\_\_ OSIS #: \_\_\_\_\_

Examiner / Title: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

*Please complete the evaluation information on the student named above.*

Device:	Selection Mode:
Switch Type:	Switch Site/ Position:

**I. Device Set-up and Positioning**

A. Symbol System used:

<i>1. Photographs</i>		<i>2. Pictures</i>	
<i>3. Mayer-Johnson symbols</i>		<i>4. Blissymbols</i>	
<i>5. Written words</i>		<i>6. Combination</i>	
<i>7. Other (please describe)</i>			

B. Vocabulary Content: list vocabulary used on overlays during assessment

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C. Describe position of device, and display set-up during assessment(s).  
Include size and spacing of symbols:

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D. Student's position when accessing device. Include any adaptive seating if used:

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**II. Trial use** - *Is the student using the communication device appropriately and efficiently?*

**Yes/No**

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1. Do you observe initiation by the student with the device?

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2. Does the symbol selection appear to be adequate?

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Indicate symbol system:

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3. Is the student taking turns in the language interchange?

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4. Is the vocabulary selection appropriate?

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5. Is the output meeting the student's needs?

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6. Is the student accessing the device appropriately?

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7. Is the position of the device appropriate?

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8. Does the student use the device functionally?

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a. On/Off

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b. Change overlays

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9. Is the student motivated to use the device?

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Comments: Please elaborate on context and time of day which device was used. Indicate if responses were independent or required examiner cues and/or prompts.

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**III. Describe any spontaneous communication using device**

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**IV. Student reaction**

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**V. Additional information**

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**EQUIPMENT EVALUATION - COMPUTER**

Student Name: \_\_\_\_\_ OSIS #: \_\_\_\_\_

Examiner / Title: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

*Please complete the evaluation information on the student named above.*

Computer:	Selection Mode:
Adaptive Device:	Switch:

**I. Seating/Posture** *(should be done in conjunction with a physical therapist)*

A. Student's sitting posture

\_\_\_\_\_

\_\_\_\_\_

B. Adaptive seating

\_\_\_\_\_

\_\_\_\_\_

C. Seating used during assessment:

<i>Classroom Chair</i>	<i>Adapted Chair</i>	<i>Manual Wheelchair</i>	<i>Power Wheelchair</i>

**II. Computer Set-Up**

A. Computer table used *(indicate optimal position)*

\_\_\_\_\_

\_\_\_\_\_

B. Monitor Specifications / Adaptations

\_\_\_\_\_

\_\_\_\_\_

C. Special Needs for Computer output and/or feedback:

\_\_\_\_\_

\_\_\_\_\_

**III. Keyboard Access** – Describe the following:

- A. Type of keyboard used for assessment \_\_\_\_\_
- B. Size of Keyboard: \_\_\_\_\_
- C. Placement of Keyboard: \_\_\_\_\_
- D. Mounting System: \_\_\_\_\_
- E. Right Hand Use: \_\_\_\_\_
- F. Left Hand Use: \_\_\_\_\_
- G. Is a keyguard required? \_\_\_\_\_
- H. List any Special Adaptations (*head pointer, hand pointer, light pointer, knobs, etc.*)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**IV. Adaptive Devices**

- A. Keyboard modifications: \_\_\_\_\_
- B. Scanning/Switch Access: \_\_\_\_\_
- C. Mouse Emulation (describe below): \_\_\_\_\_
- D. Touch Window: \_\_\_\_\_
- E. Discover Ke:nx: \_\_\_\_\_
- F. Other (specify and describe below): \_\_\_\_\_
- I. Emulator (specify device and positioning): \_\_\_\_\_  
\_\_\_\_\_
- J. Other : \_\_\_\_\_  
\_\_\_\_\_

**VI. Independence** – Describe student's ability to do the following:

- A. Inserts disk into disk drive: \_\_\_\_\_
- B. Turns computer on/off: \_\_\_\_\_
- C. Can carry portable computer: \_\_\_\_\_
- D. Motivated to use the computer: \_\_\_\_\_
- E. Describe teacher assistance required for all computer tasks  
\_\_\_\_\_  
\_\_\_\_\_

**VII. Software**

Please include a narrative on the types of software used, the objectives for the software, and adaptations, if any.

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Use this form **ONLY** for school-based assessments.

**EQUIPMENT RECOMMENDATIONS**

Student Name: \_\_\_\_\_ OSIS #: \_\_\_\_\_

Examiner / Title: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

*The following is the recommended equipment for the above named student:*

Augmentative Communication:

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Computer

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Access and Mounting

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Software:

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Other:

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Assistive Technology Equipment Assessment

District 75  
400 First Avenue  
New York, NY 10010

**Assistive Technology Equipment Assessment**

**Evaluation Information**

**Teacher**

Student \_\_\_\_\_ D/O/B \_\_\_\_\_  
Teacher's Name \_\_\_\_\_ Date \_\_\_\_\_

*Directions: Please complete the information on the student named above. Check all that apply and describe.*

**I. General Information**

A. Classroom Description:

1. Number of students \_\_\_\_\_
2. Support Personnel: Classroom paraprofessional \_\_\_\_\_  
One to one paraprofessional \_\_\_\_\_
3. Number of students who use a communication system? \_\_\_\_\_  
Please specify type of communication system and the number of students using that type of device.
  - a. manual board \_\_\_\_\_
  - b. light talker \_\_\_\_\_
  - c. computer \_\_\_\_\_
  - d. other \_\_\_\_\_

B. Vision:

1. Date and results of most recent visual exam:

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C. Hearing:

1. Date and results of most recent hearing exam:

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2. Describe the student's auditory attending skills

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3. List medications that are being taken:

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E. Does the student have seizures/convulsions? Yes \_\_\_\_\_ No \_\_\_\_\_

D. Is the student a self feeder? Yes \_\_\_\_\_ No \_\_\_\_\_  
How long does it take him/her to eat?

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F. Does the student have opportunity to make choices during mealtime?  
Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please give examples:

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E. Is the student involved in any behavior modification program?  
Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please describe

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## II. Motor Functioning

*Check appropriate answer.*

A. Locomotion:

1. Ambulation:

- a. independent walker \_\_\_\_\_
- b. walks with assistance of another person \_\_\_\_\_
- c. walks with assistive device (crutches, walker, braces) \_\_\_\_\_

2. Wheelchair function:

- a. sits independently in wheelchair \_\_\_\_\_
- b. sits in wheelchair with specialized support \_\_\_\_\_
- c. uses wheelchair independently (mobility) \_\_\_\_\_

3. Uses other classroom furniture. \_\_\_\_\_  
Describe

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B. Upper Extremity Use:

- 1. a. Uses both hands \_\_\_\_\_ b. Uses right hand \_\_\_\_\_
- c. Uses left hand \_\_\_\_\_ d. Other: \_\_\_\_\_

2. Can use the following to write with or scribble (check all that apply):  
a. pencil \_\_\_\_\_ b. crayon \_\_\_\_\_ c. marker \_\_\_\_\_  
d. typewriter \_\_\_\_\_ e. pointer \_\_\_\_\_ f. other: \_\_\_\_\_

**III. Cognitive Functioning**

A. Object Understanding:

- \_\_\_\_\_ aware of object not visibly present  
\_\_\_\_\_ aware of location (e.g., food in refrigerator)  
\_\_\_\_\_ aware of possession (own or family member)  
\_\_\_\_\_ functional object use  
\_\_\_\_\_ uses objects to pretend  
\_\_\_\_\_ has sense of cause and effect

B. Readiness Skills:

1. Identifies objects: Yes \_\_\_\_ No \_\_\_\_ How: \_\_\_\_\_  
Examples  
\_\_\_\_\_  
\_\_\_\_\_

2. Identifies: Photos \_\_\_\_ Pictures \_\_\_\_ Line Drawings \_\_\_\_  
How:  
\_\_\_\_\_  
\_\_\_\_\_

C. Academic Skills:

1. Identifies numerals: Yes \_\_\_\_ No \_\_\_\_ How: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Has sight word recognition: Yes \_\_\_\_ No \_\_\_\_ How many words: \_\_\_\_

3. Spelling level \_\_\_\_ Spelling level determined by:  
\_\_\_\_\_  
\_\_\_\_\_

4. Reading level \_\_\_\_ Reading level determined by:  
\_\_\_\_\_  
\_\_\_\_\_

5. Instructional reading method:  
Phonetic \_\_\_\_ Sight Word \_\_\_\_ Other \_\_\_\_

- 4. Handwriting:  
Manuscript \_\_\_\_ Cursive \_\_\_\_
- 5. Typing:  
with guard \_\_\_\_ without guard \_\_\_\_ electric typewriter \_\_\_\_

**IV. Desire to Communicate**

- A. What does the student usually do when his/her message is not understood?  
\_\_\_\_ nothing (quits trying)  
\_\_\_\_ repeats message  
\_\_\_\_ expands or changes message  
\_\_\_\_ other: Describe \_\_\_\_\_
- B. Does the student initiate communication / interaction?  
always \_\_\_\_ frequently \_\_\_\_ occasionally \_\_\_\_ seldom \_\_\_\_ never \_\_\_\_
- C. Does the student respond to communication / interaction?  
always \_\_\_\_ frequently \_\_\_\_ occasionally \_\_\_\_ seldom \_\_\_\_ never \_\_\_\_

**V. Communication**

- A. Does the student understand most of what is said to him/her?  
Yes \_\_\_\_ No \_\_\_\_ What kind of response indicates that he/she understands?  
Give examples \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- B. Present means of communication:  
intelligible speech \_\_\_\_ semi-intelligible speech \_\_\_\_ vocalizations \_\_\_\_  
sign language \_\_\_\_ communication board \_\_\_\_ electronic device \_\_\_\_  
reliable yes/no \_\_\_\_ facial expressions \_\_\_\_  
other (please specify): \_\_\_\_\_
- C. Describe any body movements that accompany or are initiated by attempts to communicate  
\_\_\_\_\_  
\_\_\_\_\_
- D. Where does the student initiate communication?  
at play \_\_\_\_ on school bus \_\_\_\_ in academic setting \_\_\_\_  
at home \_\_\_\_ in lunchroom \_\_\_\_  
other (please describe): \_\_\_\_\_
- E. What does the student like to communicate about?  
family \_\_\_\_ friends \_\_\_\_ sports \_\_\_\_ music \_\_\_\_ TV \_\_\_\_  
other (describe): \_\_\_\_\_

F. Who does the student communicate with?  
peers \_\_\_\_ adults \_\_\_\_ familiar persons \_\_\_\_  
unfamiliar people' \_\_\_\_ other: \_\_\_\_\_

G. How successful is his/her communication in the classroom?  
\_\_\_\_ not at all  
\_\_\_\_ few words understood only by familiar persons  
\_\_\_\_ can make most wants/needs known (e.g. play, TV, etc.)

H. Have any communication techniques been tried? Give results:  
\_\_\_\_\_  
\_\_\_\_\_

Comments:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**VI. Curriculum**

A. Describe the curriculum presently being used with this student.  
\_\_\_\_\_  
\_\_\_\_\_

B. How much time does the student spend in small groups, large groups, or one to one?  
\_\_\_\_\_  
\_\_\_\_\_

C. Is a computer available for the student's use? Yes \_\_\_\_ No \_\_\_\_  
Is the student using a computer? Yes \_\_\_\_ No \_\_\_\_  
Where and what kind? \_\_\_\_\_  
How is it accessed? \_\_\_\_\_

B. If the student had a more appropriate communication system, would there be opportunities for him/her to communicate?  
1. with peers Yes \_\_\_\_ No \_\_\_\_  
2. with unfamiliar adults Yes \_\_\_\_ No \_\_\_\_  
3. with familiar adults Yes \_\_\_\_ No \_\_\_\_  
4. without an adult present Yes \_\_\_\_ No \_\_\_\_

**VII. Student Profile**

A. What do you feel are the student's major assets?

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B. What do you perceive as the students major problems?

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C. Do you see a major discrepancy between what the student understands and what he/she can express to others? Please specify.

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D. What do you expect assistive technology will enable the student to do that he/she cannot currently do?

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*Please feel free to attach any other information that you feel would help in the evaluation process.*

**Technology Solutions  
District 75  
400 First Avenue  
New York, NY 10010**

**Assistive Technology Equipment Assessment**

**Evaluation Information**

**Speech and Language Therapy**

Student \_\_\_\_\_ Date of Birth \_\_\_\_\_

Class/Program \_\_\_\_\_

Examiner \_\_\_\_\_ Date of Evaluation \_\_\_\_\_

Instructions: Please complete the Speech/Language Therapy information on the student named above. Check all that apply to the student and describe.

**I. Means of Communication/Interaction**

\_\_\_\_\_ a. Gestures \_\_\_\_\_

\_\_\_\_\_ b. Facial Expressions \_\_\_\_\_

\_\_\_\_\_ c. Vocalizations \_\_\_\_\_

\_\_\_\_\_ d. Verbalizations (somewhat intelligible speech) \_\_\_\_\_

\_\_\_\_\_ e. Intelligible Speech \_\_\_\_\_

\_\_\_\_\_ f. Verbal Yes/No Response \_\_\_\_\_

\_\_\_\_\_ g. Non-Verbal Yes/No Response \_\_\_\_\_

\_\_\_\_\_ h. Sign Language \_\_\_\_\_

\_\_\_\_\_ i. Manual Communication Board (see appendix A): \_\_\_\_\_

\_\_\_\_\_ j. Electronic Communication Device (see appendix A): \_\_\_\_\_

\_\_\_\_\_ k. Describe student's preferred system(s) of communication/interaction:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**II. Present Communication Skills**

- \_\_\_ a. No interest in communicating \_\_\_\_\_
- \_\_\_ b. Resists communicating \_\_\_\_\_
- \_\_\_ c. Calls attention to self \_\_\_\_\_
- \_\_\_ d. Becomes frustrated \_\_\_\_\_
- \_\_\_ e. Responds but does not initiate communication \_\_\_\_\_
- \_\_\_ f. Initiates interaction/communication with others \_\_\_\_\_
- \_\_\_ g. Indicates basic wants/needs (toilet, drink) \_\_\_\_\_
- \_\_\_ h. Indicates feelings (happy, frustrated, fear) \_\_\_\_\_
- \_\_\_ i. Indicates physical state (tired, uncomfortable) \_\_\_\_\_
- \_\_\_ j. Indicates preference when given choice \_\_\_\_\_
- \_\_\_ k. Requests objects and events that are present \_\_\_\_\_
- \_\_\_ l. Requests objects and events that are not present \_\_\_\_\_
- \_\_\_ m. Requests information \_\_\_\_\_
- \_\_\_ n. Indicates rejection \_\_\_\_\_
- \_\_\_ o. Talks about events that have occurred \_\_\_\_\_
- \_\_\_ p. Talks about upcoming or future events \_\_\_\_\_
- \_\_\_ q. Engages in social conversation (hi, how are you?, thank you) \_\_\_\_\_
- \_\_\_ r. Repairs miscommunications (will you repeat that? it's not on my board)  
\_\_\_\_\_

**III. Auditory Functioning**

A. Hearing tests given:

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

Results and Follow-up \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Does student receive hearing services? \_\_\_\_\_ If yes, please consult H.E.S. provider and describe student's hearing ability below.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

B. Check ALL that apply:

	<i>Always</i>	<i>Frequently</i>	<i>Occasionally</i>	<i>Seldom</i>	<i>Never</i>
<i>Hears well</i>					
<i>Wears hearing aid</i>					

Type of hearing aid

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C. Auditory Sensitivity and Attention (Check ALL that apply):

<i>Loud noises</i>	Tolerates sudden introduction ____	Reflexively reacts to sudden noises ____	Can tolerate if gradually introduced ____
<i>In quiet environment</i>	Listens to stories ____	Listens to music ____	Follows one step directions ____

**IV. Auditory Memory and Discrimination (Check ALL appropriate answers):**

Responds to commands      1-step \_\_\_\_      2-step \_\_\_\_      3-step \_\_\_\_

YES      NO

Recognizes familiar environmental sounds		
Recognizes familiar voices		
Discriminates similar sounding words (sock/rock)		
Discriminates synthetic speech output		

**V. Visual Functioning**

A. Date of most recent visual exam and results (attach report if available).

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B. Does student receive vision services? \_\_\_\_ If yes, please consult VES provider

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C.

	<i>Always</i>	<i>Frequently</i>	<i>Occasionally</i>	<i>Seldom</i>	<i>Never</i>
<i>Wears glasses</i>					

D. Can the student voluntarily move his/her eyes without moving his/her head?  
Yes \_\_\_\_\_ No \_\_\_\_\_

E. Describe the student's visual attending behaviors:

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F. Can student scan? Vertically \_\_\_\_\_ Horizontally \_\_\_\_\_

**VI. Cognitive Functioning**

A. Formal Testing

1. Name of Test \_\_\_\_\_

2. Date of Test \_\_\_\_\_

3. Results

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4. List any adaptations made to test

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B. Attach other test results, if applicable

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C. Informal testing/observation

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**VIII. Student Profile**

A. What do you feel are the student's major assets?

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B. What do you perceive as the students major problems?

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C. Do you see a major discrepancy between what the student understands and what he/she can express to others? Please specify.

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D. What do you expect assistive technology will enable the student to do that he/she cannot currently do?

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## Appendix A

Student's Name \_\_\_\_\_

Date of Evaluation \_\_\_\_\_

### Current Augmentative Communication System

Directions: Please describe as fully as possible, the augmentative communication system currently in use.

#### I. Symbol Sets/Systems Used

A. Objects \_\_\_\_\_

B. Symbols \_\_\_\_\_

- |                                |                                 |
|--------------------------------|---------------------------------|
| 1. Photographs _____           | 5. Written words _____          |
| 2. Pictures _____              | 6. Combination _____            |
| 3. Mayer Johnson symbols _____ | 7. Other, please describe _____ |
| 4. Blissymbolics _____         | _____                           |

#### II. Describe Display Set-up (attach photograph or sketch if possible - include mode e.g., direct select, coded pitch, etc.)

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#### III. Size and Spacing of Symbols

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**IV. Vocabulary Content**

**Please give number of words and list words in each category.**

A. People \_\_\_\_\_  
\_\_\_\_\_

B. Common Nouns \_\_\_\_\_  
\_\_\_\_\_

C. Verbs \_\_\_\_\_  
\_\_\_\_\_

D. Adjectives \_\_\_\_\_  
\_\_\_\_\_

E. Prepositions \_\_\_\_\_  
\_\_\_\_\_

F. Temporal \_\_\_\_\_  
\_\_\_\_\_

G. Social Amenities \_\_\_\_\_  
\_\_\_\_\_

H. Questions \_\_\_\_\_  
\_\_\_\_\_

I. Phrases \_\_\_\_\_  
\_\_\_\_\_

J. Alphabet \_\_\_\_\_

K. Numbers \_\_\_\_\_  
\_\_\_\_\_

L. Other \_\_\_\_\_  
\_\_\_\_\_

**V. Number of Words in Average Message** (please check)

<i>1</i>	<i>2 – 3</i>	<i>4 – 5</i>	<i>More</i>

**VI. Electronic Device Information**

A. Communication device currently used

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B. Length of time used

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C. Any special repairs or adaptations

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D. Mounting/Placement

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E. Number of Communication phrases pre-programmed (attach list if possible)

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**VII. Accessing**

A. Method of Accessing

<i>Direct selection</i>	<i>Scanning</i>

B. Techniques to access display

	<i>Switch</i>	<i>Pointer</i>
Type		
Head		
Finger		
Other		

C. Accuracy of accessing (please describe):

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**District 75  
400 First Avenue  
New York, NY 10010**

**Assistive Technology Equipment Assessment**

**Evaluation Information**

**Physical Therapy**

Student \_\_\_\_\_ Date of Birth \_\_\_\_\_

Class/Program \_\_\_\_\_

Examiner \_\_\_\_\_ Date of Evaluation \_\_\_\_\_

*Instructions: Please complete the Physical Therapy information on the student named above.*

**I. Physical**

A. Joint Stability - indicate right, left or bilateral in the spaces below

Joint	Seated	Subluxes	Dislocations	Comment
<i>Hip</i>				
<i>Shoulder</i>				
<i>Elbow</i>				
<i>Thumb</i>				
<i>MCP/PIP</i>				

B. List contractures which interfere with sitting in chair.

\_\_\_\_\_

\_\_\_\_\_

C. List contractures affecting range of motion interfering with active reach.

\_\_\_\_\_

\_\_\_\_\_

D. Describe student's back (tone, curves, flexibility).

\_\_\_\_\_

\_\_\_\_\_

E. Describe type, distribution (e.g., location in body or extremity), symmetry, and predominant pattern (e.g., flexor, extensor).

\_\_\_\_\_

\_\_\_\_\_

F. What differences are noted when student is at rest or engaged in active play or cognitive tasks?

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G. Reflex reactions and precipitating factors if it interferes with purposeful activity.

\_\_\_\_\_ ATNR (face toward right) \_\_\_\_\_

\_\_\_\_\_ ATNR (face toward left) \_\_\_\_\_

\_\_\_\_\_ STNR (Flexion) \_\_\_\_\_

\_\_\_\_\_ STNR (Extension) \_\_\_\_\_

\_\_\_\_\_ Startle/Moro \_\_\_\_\_

H. Equilibrium, Protective, and Headrighting Reactions

1. Equilibrium tested in sitting

<i>Absent</i>	<i>Functional</i>	<i>Mature</i>

2. Protective responses tested in sitting

<i>Absent</i>	<i>Functional</i>	<i>Mature</i>

**II. Motor Development**

A. Head

<i>Erect</i>	<i>Tipped downward</i>	<i>Tilted to R/L</i>	<i>Tipped upward</i>

B. Sits independently

<i>Ring</i>	<i>Long</i>	<i>Indian</i>	<i>Side R/L</i>
unable to sit independently _____			

C. On all fours

<i>Crawls</i>	<i>Bunny hops</i>	<i>Creeps</i>	<i>Unable</i>

D. Walks:

<i>With assistance</i>	<i>Without assistance</i>	<i>With aid(s)</i>	<i>Without aid(s)</i>
<i>Unable to walk</i> _____			

**III. Motor Functioning (range and strength)**

*Describe in terms of ability to access communication/computer access devices.*

A. Range of upper body movement (i.e., head, shoulder, arms, hands, fingers)

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lower extremities (i.e., ability to use foot, knee, or other site for switch access)

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B. Muscle strength to activate using upper and/or lower extremities:

*Grasp* \_\_\_\_\_

*Release* \_\_\_\_\_

*Depression* \_\_\_\_\_

**IV. Positioning**

A. List all positions in which student is routinely placed at school. List in order from least to most time spent, as well as who positions the student.

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B. List activities the student can perform in each position.

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---

C. State position in which student's communication is best understood.

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D. Describe adaptations made in wheelchair, classroom chairs, and other positioning devices.

---

---

E. List other non-positioning appliances or adaptive equipment.

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**V. Communication/Interaction in Physical Therapy**

A. Present means of communication

<i>Gestures</i> ____	<i>Facial expressions</i> ____	<i>Vocalizations</i> ____
<i>Sign Language</i> ____	<i>Yes/No Reliability</i> ____	<i>Semi-intelligible</i> ____
<i>Intelligible Speech</i> ____	<i>Communication Board</i> ____	<i>Electronic Devices</i> ____
<i>Other</i> _____		

E. Student's communication needs in physical therapy are:

<i>Social</i>	<i>Making choices</i>	<i>Indicating basic needs</i>	<i>Other</i>

C. Describe any body movements that accompany or are initiated by attempts to communicate

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D. List communication partners during therapy, in addition to therapist

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**VI. Surgery**

List recent or proposed orthopedic/neurological surgery. Give date, if possible.

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**VII. Student Profile**

A. Describe student's major assets

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B. Describe student's major difficulties

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**District 75  
400 First Avenue  
New York, NY 10010**

**Assistive Technology Equipment Assessment**

**Evaluation Information**

**Occupational Therapy**

Student \_\_\_\_\_ Date of Birth \_\_\_\_\_

Class/Program \_\_\_\_\_

Examiner \_\_\_\_\_ Date of Evaluation \_\_\_\_\_

Instructions: Please complete the Occupational Therapy information on the student named above.

**I. Physical**

A. Joint Stability - indicate right, left or bilateral in the spaces below.

Joint	Seated	Subluxes	Dislocations	Comment
<i>Hip</i>				
<i>Shoulder</i>				
<i>Elbow</i>				
<i>Thumb</i>				
<i>MCP/PIP</i>				

B. List contractures and limitations in range of motion which interfere with active reach.

\_\_\_\_\_

\_\_\_\_\_

C. List contractures which interfere with sitting in a chair.

\_\_\_\_\_

\_\_\_\_\_

D. Describe student's back (tone, curves, flexibility).

\_\_\_\_\_

\_\_\_\_\_

E. Describe student's muscle tone in trunk and upper and lower extremities when

*At rest*

\_\_\_\_\_

*Active*

\_\_\_\_\_

F. Indicate reflexes which interfere with the student's ability to reach, and state precipitating factors:

ATNR (face turned right) \_\_\_\_\_

ATNR (face turned left) \_\_\_\_\_

STNR (flexion) \_\_\_\_\_

Startle/Moro \_\_\_\_\_

G. Hand functioning:

1. Grasp (describe)

<i>1-inch block:</i>	R _____
	L _____
<i>Opposition:</i>	R _____
	L _____
<i>Pencil:</i>	R _____
	L _____

2. Voluntary release

	<i>Able</i>	<i>Unable</i>
<i>Right</i>		
<i>Left</i>		

3. Finger isolation (indicate): (R) \_\_\_\_\_ (L) \_\_\_\_\_

4. Dominance: R \_\_\_\_ L \_\_\_\_ Mixed \_\_\_\_ Unknown \_\_\_\_

5. Describe any modifications in positioning to enhance student's hand use:

\_\_\_\_\_

\_\_\_\_\_

H. Pointing

1. Method

eye \_\_\_\_ head \_\_\_\_ elbow \_\_\_\_ foot \_\_\_\_ finger \_\_\_\_

other \_\_\_\_\_

2. Accuracy

\_\_\_\_\_

\_\_\_\_\_

**III. Positioning (If the student receives physical therapy services it is not necessary to complete A through E)**

A. List all positions in which student is routinely placed at school. List in order from least to most time spent and who positions student

\_\_\_\_\_

\_\_\_\_\_

B. List activities the student can perform in each position

\_\_\_\_\_

C. State position in which student's communication is best understood

---



---

D. Describe adaptations made in wheelchair, classroom chairs, or other positioning devices

---



---



---

E. List other non-positioning appliances or adaptive equipment

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---



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**IV. Perceptual Skills**

A. Does the student display tactile defensiveness? Yes \_\_\_ No \_\_\_

*If yes, where*

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B. Date of most recent visual exam and results

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C. Can student separate the movement of his/her eyes from the head?

*Yes\_\_ No\_\_*

D. Describe the student's ability in each of the following areas:

*tracking* \_\_\_\_\_

*form discrimination* \_\_\_\_\_

*figure ground* \_\_\_\_\_

*position in space* \_\_\_\_\_

*visual memory* \_\_\_\_\_

*visual attending behavior* \_\_\_\_\_

**V. Communication/Interaction in Physical Therapy**

A. Present means of communication

<i>Gestures</i> _____	<i>Facial expressions</i> _____	<i>Vocalizations</i> _____
<i>Sign Language</i> _____	<i>Yes/No Reliability</i> _____	<i>Semi-intelligible</i> _____
<i>Intelligible Speech</i> _____	<i>Communication Board</i> _____	<i>Electronic Devices</i> _____
<i>Other</i> _____		

B. Student's communication needs in physical therapy are:

<i>Social</i>	<i>Making choices</i>	<i>Indicating basic needs</i>	<i>Other</i>

C. Describe any body movements that accompany or are initiated by attempts to communicate

---

---

---

D. List communication partners during therapy, in addition to therapist

---

---

**VI. Surgery**

List recent or proposed orthopedic/neurological surgery. Give date, if possible.

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---

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**VII. Student Profile**

A. Describe student's major assets

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B. Describe student's major difficulties

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**District 75  
400 First Avenue  
New York, NY 10010**

**Assistive Technology Equipment Assessment**

**Evaluation Information**

**Parent**

Student \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Person Completing Form \_\_\_\_\_ Date \_\_\_\_\_

*Instructions: Circle or check ALL appropriate answers. Use back of sheet for additional information. Mark N/A for all questions not applicable.*

**I. Family Information**

A. Mother's name \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

Occupation \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

B. Father's name \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

Occupation \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

C. Legal Guardian's name \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

Occupation \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**II. Social/Medical Information**

A. List doctors and therapists that the child is seeing:

Dr. \_\_\_\_\_

Address \_\_\_\_\_

Dr. \_\_\_\_\_

Address \_\_\_\_\_

Therapists seen outside of school.

\_\_\_\_\_

B. List all medications child is taking

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C. List all procedures child has undergone.

1. Medical:	Date
<hr/>	<hr/>
<hr/>	<hr/>

2. Surgical:	Date
<hr/>	<hr/>
<hr/>	<hr/>

3. Dental:	Date
<hr/>	<hr/>
<hr/>	<hr/>

D. List all agencies (e.g. social, government or private) with which the family is involved

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E. Please attach copies of the most recent medical report for your child.

**III. Communication**

A. Child's communication method(s):

1. Describe all methods of communication used by your child (communication boards, sign language, etc

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2. Does child initiate communication/interaction?  
always \_\_\_ frequently \_\_\_ occasionally \_\_\_ seldom \_\_\_ never \_\_\_

3. Does child respond to communication/interaction?  
always \_\_\_ frequently \_\_\_ occasionally \_\_\_ seldom \_\_\_ never \_\_\_

4. How does child communicate personal needs (i.e., toilet, hunger, pain)?

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5. Describe what child does when his first message is not understood.

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6. Do you see a discrepancy between what the child understands and what he is able to express to others? Please describe.

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7. How does your child interact with familiar adults (i.e., parents, grandparents, etc

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8. How does your child interact with family peers or siblings? Describe how they play together, who takes charge, how they communicate, etc.

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**IV. Environments**

A. Outside Home/Community

1. List places your child goes in the community

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2. Does your child have the opportunity to visit friends, relatives, etc.? Describe

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B. At Home

1. How is your child positioned at home? List any adaptations.

<i>Sitting</i> ____	<i>Semi-reclined</i> ____	<i>On Back</i> ____
<i>On Stomach</i> ____	<i>On Right or Left Side</i> ____	

2. List all activities child enjoys participating in while at home.

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**V. Parent Comments**

A. Please take time to write about your child's special qualities

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B. What do you expect a communication device to enable your child to do that he/she is unable to do with his/her current mode of communications.

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Please feel free to send other information you feel would help in the evaluation process.

The above information and all data obtained from various agencies and professionals listed may be used by the evaluation team for the purpose of evaluating your child.

Date \_\_\_\_\_ Parent or Legal Guardian \_\_\_\_\_

**District 75  
400 First Avenue  
New York, NY 10010**

**Assistive Technology Equipment Assessment**

**INFORMACIÓN EVALUATIVA  
PADRES/ENCARGADO LEGAL**

Alumno(a) \_\_\_\_\_ Fecha de nacimiento \_\_\_\_\_

Dirección \_\_\_\_\_

Persona completando este formulario \_\_\_\_\_ Fecha \_\_\_\_\_

Instrucciones: Favor de contestar todas las preguntas en este formulario que sean apropiadas. Usa la parte de atrás de al página correspondiente si necesita elaborar algunas de sus respuestas o si desea proveer información adicional. Marque "N/A" todas preguntas que no tengan que ver con su caso.

**I. Información Familiar**

A. Nombre de la madre \_\_\_\_\_ Edad \_\_\_\_\_

Dirección \_\_\_\_\_

Ocupación \_\_\_\_\_

Teléfono del hogar \_\_\_\_\_ Teléfono del trabajo \_\_\_\_\_

B. Nombre de la padre \_\_\_\_\_ Edad \_\_\_\_\_

Dirección \_\_\_\_\_

Ocupación \_\_\_\_\_

Teléfono del hogar \_\_\_\_\_ Teléfono del trabajo \_\_\_\_\_

C. Nombre del encargado legal \_\_\_\_\_ Edad \_\_\_\_\_

Dirección \_\_\_\_\_

Ocupación \_\_\_\_\_

Teléfono del hogar \_\_\_\_\_ Teléfono del trabajo \_\_\_\_\_

**II. INFORMACIÓN SOCIAL Y MÉDICA**

A. Escriba los nombres de todos los médicos y terapistas que trabajan con su niño:

Dr. \_\_\_\_\_

Dirección \_\_\_\_\_

Dr. \_\_\_\_\_

Dirección \_\_\_\_\_

Otros terapistas que brindan servicios a su niño en al práctica privada tales como:  
terapistas del habia, físcia y ocupacional.

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B. Anote todas las medicinas que su niño esté tomando

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C. Indique todos los procedimientos que su niño ha tenido

1. MÉDICOS FECHA

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2. CIRUGÍAS FECHA

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3. DENTALES FECHA

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D. Indique todas las agencias sociales, privads o del gobiern que trabajan con su familia

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E. Por favor incluya copias de los informes médicos más recientes que tengan de su niño.

### III. Comunicación

A. Sistema(s) de comunicación:

1. Describa todos los metodos de comunicación que usa su niño.  
(ejemplos, tablas de comunicación, gestos manuales o símulos, etc.)

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2. Intenta su niño iniciar comunicación o interacción?

siempre      frecuentamente      ocasionalmente      casi nunca      nunca

3. Responde su niño a la comunicación o interacción iniciada por otros?

siempre      frecuentamente      ocasionalmente      casi nunca      nunca

4. Cómo le comunica su niño sus necesidades personales? (Ejemplo, ir al baño, si tiene hambre, dolor, etc.)

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5. Describa la reacción de su niño cuando usted no entiende el mensaje que él intenta comunicarle.

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6. Ve usted alguna diferencia entre el grado de comprensión de su niño y lo que él puede expresar a otros? Explique detalladamente.

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7. Cómo se comunica su niño con los adultos de familia? Ejemplo: padres, abuela, tios, etc.

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8. Cómo interactúa su niño con sus familiares y amigos? Describa cómo ellos juegan, cómo se comunican, quién lleva el control, etc.

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**IV. Medio Ambiente**

A. En la comunidad

1. Indique los lugares que su niño asiste en la comunidad

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2. Tiene su niño la oportunidad de visitar sus amigos o familiares, etc.  
Anote los lugares.  
*Describe*

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**B. En el hogar**

1. En qué posición y espacio mantiene usted a niño dentro del hogar?  
*Sentado* \_\_\_\_ *Reclinado* \_\_\_\_ *De espalda* \_\_\_\_  
*De Estómago* \_\_\_\_ *Hacia el lado izquierda o derecho* \_\_\_\_

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2. Anote todas las actividades que su niño disfruta mientras está en el hogar

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**V. Comentrarios de Los Padres**

- A. Favor de describimos algunas cualidades especiales que tenga su niño.

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- B. Qué espera usted su niño pueda realizar con un nuevo sistema electrónico de comunicación y que no puede realizar con el que usa actualmente.?

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Favor de sentirse libre de enviarnos cualquier información adicional que nos ayudaría en el proceso evaluativo de su niño(a).

Toda la información y los datos obtenidos de las agencias, doctores y otros profesionales serán utilizados por el grupo de evaluadores con el propósito de hacer una evaluación precisa a su niño(a).

ATEA

Fecha \_\_\_\_\_ Padre o Encargado Legal \_\_\_\_\_