Assistive Technology Assessment

Child Name________________________________ Date of Birth_____________

Date of Assessment ____

Assistive Technology Assessment Team Members:

Name	Initial	Role	Phone Number

Desired Outcome(s)/Result(s) from Individualized Family Support Plan (IFSP):

____

____

____

Is it necessary to use assistive technology to accomplish the outcome(s)? ________________

Is assistive technology necessary to enhance the child's *current* development and functioning during the time the child is eligible for and receiving early intervention services through Early Steps? ___________

How will assistive technology be used to increase, maintain or improve functional capabilities of the child?

____

____

____

Describe range of options considered (low- to high-tech).

Option/Item	Cost

List community service groups such as Lions or Elks clubs that were contacted regarding partial or total funding.

Group	Date Contacted	Response

AT Assessment Team Recommendation(s):

____

____

Assistive Technology Assessment

Child Name_________________________________ Date of Birth_____________

Date of Assessment ____

____

____

____

Assistive Technology Assessment

Child Name________________________________ Date of Birth_____________

Date of Assessment ____

Implementation Strategies

Trial period for use of assistive technology before purchase, if applicable:

____

____

____

Support and training of family members, caregivers and professionals:

____

____

____

Plan for repair and maintenance:

____

____

____