Assistive Technology Assessment Form

Child Demographics				
Child Name	Date of Birth	Assessment Date	Diagnosis Code (ICD-10)	Insurance Information

Assistive Technology Assessment Team Members			
Provider Name	Provider Code	Provider Type	Medicaid ID

Reason for Assistive Technology is being recommended:
Child's goals and outcomes that will be addressed with this technology: *(Please include the child's IFSP outcome and date of the IFSP)*
How will assistive technology increase, maintain, or improve the child's functional capabilities?
Other funding sources (To be completed by the SC)
Please describe the training plan for the parents and caregivers:

Assessor Name	Signature	Date
Service Coordinator	**Signature**	**Date**

DRAFT