Assistive Technology Extended Assessment Plan

Date of Extended Assessment Planning: ______________________________

Student Data

Student Name: ______________________________
Parent Name(s): ______________________________
Parent Phone: ______________________________
Parent Email: ______________________________
Parent Address: ______________________________
____

Date of Birth: ____________ CA: ____________
Disability: ______________________________
IEP Date: ______________________________
Medicaid ID# *(If applicable)* ______________________________
Medical Diagnosis *(If applicable)* ______________________________
Social Security # ______________________________
Grade/Placement: ______ Student #: ____________
School: ______________________________
School Address: ______________________________
____
School Phone: ______________________________

Team Members

AT Extended Assessment Coordinator
Name ______________________________
Title ______________________________
Phone ______________________________
Email ______________________________

Other Team Members
Name ____________________ Title ____________
Phone ______________________________
Email ______________________________

Name ____________________ Title ____________
Phone ______________________________
Email ______________________________

Name ____________________ Title ____________
Phone ______________________________
Email ______________________________

Name ____________________ Title ____________
Phone ______________________________
Email ______________________________

Overall Goal for Device Use

Goal for Device:

____
____
____

How will we know if the trial is successful?

____
____
____

What level of achievement is reasonable to expect during the trial period?

____
____
____

How will we know if the trial is not working (What criteria will we use to stop)?

____
____
____

Bowser and Reed • Copyright • April, 1998 from: Education Tech Points: A Framework for Assistive Technology Planning

Customary Environments Where Devices Will Be Used

1. Environment: ______
   Tasks: ______
   Person responsible for implementation: ______
   Days to be used: ______
   Times to be used: ______

2. Environment: ______
   Tasks: ______
   Person responsible for implementation: ______
   Days to be used: ______
   Times to be used: ______

3. Environment: ______
   Tasks: ______
   Person responsible for implementation: ______
   Days to be used: ______
   Times to be used: ______

Specific Devices For Trial

Device #1 ______

Date of trial Initiation: ______ Minimum length of trial period: ______
Device trial review date: ______
Source of Device for Trial: ______
Contact person for technical assistance for trial: ______
Manufacturer: ______ Manufacturer technical assistance number: ______
Comments: ______

______

Device #2 ______

Date of trial initiation: ______ Minimum length of trial period: ______
Device trial review date: ______
Source of device for trial: ______
Contact person for technical assistance for trial: ______
Manufacturer: ______ Manufacturer technical assistance number: ______
Comments: ______

______

Device #3 ______

Date of trial initiation: ______ Minimum length of trial period: ______
Device trial review date: ______
Source of Device for Trial: ______
Contact person for technical assistance for trial: ______
Manufacturer: ______ Manufacturer Technical Assistance Number: ______
Comments: ______

______

Extended Assessment Summary
(To be completed at the end of the assessment)

How did the child's performance change when using the devices?

How did the student like using each device? Did the student prefer one of the devices?

What are the advantages of using the devices?

What are the disadvantages of using the devices?

How long can the child be expected to use the devices?

Extended Assessment Team Recommendation: