Assistive Technology Plan Development

Student Data	Team Members
Student Name _____	AT Extended Assessment Coordinator
Parent Name(s) _____	Name _____
Parent Phone _____	Title _____
Parent Email _____	Phone_____
Parent Address _____	Email_____
_____	
Date of Birth _____	Other Team Members
Disability _____	Name _____
IEP Date _____	Title _____
Medicaid ID# _____	Phone_____
Medical Diagnosis _____	Email_____
Social Security # _____	
Grade _____	Name _____
School _____	Title _____
School Address _____	Phone_____
_____	Email_____
School Phone _____	
School Fax _____	Name _____
	Title _____
	Phone_____
	Email_____

Overall Goal for Devices Use

Goal for student's use of the device:

_____

_____

How will we know if the trial is succes

_____

_____

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)?

_____

_____

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 Dates 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: _____
_____