Each IEP team must annually consider Assistive Technology (AT) for students with disabilities and determine whether there is a need for devices and/or services.

Tier I and II Interventions must be implemented by school based teams before a referral packet may be submitted.

### Tier 3 Expert Panel
Neutral Multidisciplinary, Multi-agency Panel Consultation to determine strategies for AT/AAC & receive consultation on matching features of technology to student goals. Leave with an action plan to guide next steps.

For SELPA Expert Panel consultation, send packet to:

Contra Costa SELPA Coordinator
**Contra Costa SELPA**
2520 Stanwell Dr., Suite 270
Concord, CA 94520
FAX: (925) 825-1124
ldomenico@ccselpa.org

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**Not making progress with current AT/AAC?**
**Differing opinions on how to implement AT/AAC?**

- Determine strategies for implementing AT/AAC
- Define potential AT/AAC outcomes and next steps
- Receive consultation on matching features of technology to student goals
- Leave with resources for exploration
- Leave with an action plan to guide next steps

---

Student’s name: ___________________________________ District: ___________________________

Reason for referral: ____________________________________________________________

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**Signature of Referring District Director**
The following documentation must be attached for all referrals for consultation (Incomplete packets will be returned):

- Release of Information that has been signed by parent (included in packet)
- Most recent IEP, including goals (highlight specific goals you would like addressed during consultation)
- Most recent psycho-educational/triennial evaluation (last complete psychological evaluation is required if file review was used for the last triennial evaluation.)
- Current evaluations from all related service providers (i.e., SLP, OT, APE, CCS)

**Do not write in this box when making a referral.**

Date received by SELPA: ________________________________
Signature: ______________________________________________________________________
Coordinator SELPA

**Action Taken:**
- Date Panel Consultation Scheduled __________________ Date Completed __________________
- Other: __________________________________________________________________________
PARENT CONSENT FOR RELEASE OF INFORMATION

This information will be shared among representatives on the AAC/AT Expert Panel from Center for Accessible Technology, California Children’s Services, Mt. Diablo USD, San Ramon Valley USD, Contra Costa SELPA, West Contra Costa USD, Speech Pathology Group, and the Contra Costa County Office of Education. All materials will be destroyed or returned to the district of residence upon completion of the AAC/AT consultation activity.

_____________________________________               ________________________
Name of Student                                      Birth date

Information to be released by:

_____________________________________
Name of Professional or Agency

_____________________________________
Street Address

_____________________________________
City, State, Zip

Information to be received by:  
Contra Costa Special Education Local Plan Area (SELPA)

Please sign and date below.

_____________________________________                      _________________________
Signature of Parent or Guardian                               Date
AT/AAC Expert Panel Request
Student Information

Student: ___________________________ D.O.B ___________ Age: __________ _ Grade_____________________

Disability (yes): _________________________________________________________________________________

Parent: ___________________________ Phone #: ___________________ E-mail: ________________________

District of Residence: ______________________________________________________________________________

Professional Initiating Request: ___________________________ Role: _______________________________________

Phone # ______________________ E-mail: _____________________________________________________________

Program Specialist: ___________________________ Phone #: __________________________

E-mail: ___________________________________________________________________________________________

Teacher: ___________________________ Phone #: __________________________

E-mail: ___________________________________________________________________________________________

Case Manager: ___________________________ Phone #: __________________________

School District Point Person for Collaboration in implementation: _________________________________

E-mail: ___________________________________________________________________________________________

School of Attendance: ___________________________ Address: ________________________________________

Please include contact names and phone numbers for all related service providers.

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<thead>
<tr>
<th>□ Speech/Language</th>
<th>□ Occupational Therapy</th>
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<tbody>
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<tr>
<th>□ DHH Services</th>
<th>□ Physical Therapy</th>
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<tr>
<th>□ Vision Services/Orientation &amp; Mobility</th>
<th>□ School Psychologist</th>
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<th>□ Behavior Support</th>
<th>□ District Technology Contact</th>
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<th>□ California Children Services</th>
<th>□ Other</th>
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What is the expectation for making this referral to the AT/AAC Expert Panel?

Vision functioning: _________________________ Date of Last Screening: ___________ Pass / Fail
List Accommodations: ____________________________

Hearing functioning: _________________________ Date of Last Screening: ___________ Pass / Fail
List Accommodations: ____________________________

Communication:
Current level of receptive language: _____________________________ Age approximation: ___________
Current level of expressive language: _____________________________ Age approximation: ___________
☐ Speech intelligibility: ___________%

Present means of communication: (Check all that are used then circle the primary method used.)
☐ Eye-gaze/eye movement ☐ Facial expressions ☐ Gestures ☐ Pointing ☐ Sign Language approximations
☐ Objects ☐ Pictures
☐ Sign Language # of signs: ______ # of combinations: ______ # of signs in a combination: ______
☐ Vocalizations, list examples: ____________________________________________________________
☐ Vowels, vowel combinations, list: ______________________________________________________
☐ Single words, list examples & approximate #: _____________________________________________
☐ 2 word/3 word utterances
☐ Communication board/book, # of pages and vocabulary: _________________________________

☐ PECS: # of pictures and vocabulary for system: __________________ Phase level: _______________
☐ Speech generating device (Name of device): _____________________________________________
Applications: ________________________________________________________________
Access method: __________________________________________ (i.e., touch screen, keyboard, mouse, switch)
☐ Writing: ________________________________________________________________
☐ Other: ________________________________________________________________

Behavior
Does the student’s behavior impede learning of self or other?  ☐ No  ☐ Yes
If yes, describe behavior and list interventions:
________________________________________________________________________________________
1. Please list any parent concerns:
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

2. What areas are impacted?
☐ Seating, Positioning and Mobility  ☐ Communication  ☐ Recreation and Leisure
☐ Mathematics  ☐ Motor Aspects of Writing  ☐ Organization
☐ Computer Access  ☐ Hearing  ☐ Vision
☐ Composition of Written Material  ☐ Reading
☐ Other:
______________________________________________________________________________________
______________________________________________________________________________________

3. What are the tasks that the student needs to be able to accomplish to meet IEP goals?
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

4. Please reference IEP goals that could be considered for AAC/AT support:
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
5. List the current interventions/accommodations the student is receiving? Are they working? Why or why not? (Attach additional pages if necessary)

Tier III (3)  (Few students)
**Intensive, Individual**
Implementers: AT/AAC Specialist          High tech solutions

Tier II (2)  (Some students)
**Targeted interventions, Intervention Plan, Progress Monitoring,**
**Explicit Instruction of AT tool**
Implementers: Specialists (OT, SLP, ISP, Psychologist, Behaviorist)
Mid-tech solutions (/AAC Consultation):

Implement by (List staff):

Tier I (1)  (Most students)
**Consideration of AT/AAC during the IEP Meeting**
Implementers: Classroom Teachers
Light technology solutions (List AT/AAC):

Implemented by (List staff):