Each IEP team must consider Assistive Technology (AT) for students with disabilities and determine whether there is a need for devices and/or services. Assistive Technology includes tools for access and independence, including those for Augmentative and Alternative Communication (AAC). These devices and/or services will change as the student develops and technology continues to change. The consideration of need for AT/AAC should be based upon the student’s unique needs and strengths.

The following packet has been designed to assist IEP teams in their consideration of AT/AAC for a student. The packet includes guidelines for consideration of AT/AAC, plus specific checklists designed to help teams complete their consideration of student need regarding AT/AAC. Additional support may be accessed through the Contra Costa County Office of Education (COE) or the Contra Costa SELPA by completing this packet and sending the appropriate documentation to one of the following contacts.

For COE District Specified Services, Assistive Technology and/or Augmentative and Alternative Communication consultation, send packet to:
Claudia Ronaldson, Principal
Mauzy School
Contra Costa County Office of Education
2964 Miranda Ave.
Alamo, CA 94507
cronaldson@cccoe.k12.ca.us
FAX: (925) 831-8691
* Please only fax or email.

For Multi-agency AT/AAC Expert Panel consultation, send packet to:
Carrie Weil
Contra Costa SELPA
2520 Stanwell Dr., Suite 270
Concord, CA 94520
cweil@ccselpa.org

Student’s name: __________________________ District: __________________________
Reason for referral: __________________________

Signature of District Director

The following documentation must be attached for all referrals for consultation:

☐ 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)

Tier I and II documents:
☐ Consideration of Assistive Technology
☐ Curriculum Accommodations/Modifications Guide
☐ WATI Assistive Technology Checklist
☐ Tier I and II Intervention forms
☐ Note any additional documents attached: ______________________________________________________________
   __________________________________________________________________________________________

Do not write in this box when making a referral.

Date distributed by Claudia Ronaldson/Carrie Weil: ________ Date Consultation Scheduled/Completed: ________

Signature: __________________________
(Claudia Ronaldson, Mauzy School /Carrie Weil, Coordinator, Contra Costa SELPA)

Action Taken:
☐ Consultation completed and recommendations submitted to student’s IEP team and Claudia Ronaldson
☐ Referral to AT/AAC Expert Team. Date sent to Carrie Weil: __________________________

Signature of specialist completing consultation: __________________________
PARENT CONSENT FOR RELEASE OF INFORMATION

For Panel Referrals:

This information will be shared among representatives on the AT/AAC Team from CCS, Mt. Diablo USD, San Ramon Valley USD, Contra Costa SELPA, and Contra Costa County. All materials will be destroyed or returned to the district of residence upon completion of the AT/AAC consultation activity.

Name of Student __________________________ Birth date __________________________

Information to be released by (school district, outside or non-public agency):

Name of Professional or Agency __________________________

Street Address __________________________

City, State, Zip __________________________

Information to be received by:
Contra Costa Special Education Local Plan Area or Contra Costa County Office of Education

Please sign and date below.

Signature of Parent or Guardian __________________________ Date __________________________
AT/AAC Consultation Request

Student Information

Student: ____________________________________________________ D.O.B ________ Age: ________ Grade __________

Disability(ies): ___________________________ Eligible for Low Incidence Services/Equipment? ________

Parent: __________________________________ Phone #: __________________ e-mail: __________________

Address: _______________________________________________________________________________________

District of Residence: ____________________________________________________________________________

Professional Initiating Request/Role: ____________________ Phone #: ______________ e-mail: ________________

Program Specialist: ____________________ Phone #: ______________ e-mail: ________________

Teacher: ____________________ Phone #: ______________ e-mail: ________________

Team Contact: ____________________ Phone #: ______________ e-mail: ________________

School of Attendance: ____________________ Address: _________________________________________________

Classroom setting: ☐ General Ed./Inclusion ☐ Resource Room ☐ Self-Contained Class ☐ COE site

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

☐ Speech/Language
Name: ____________________ ph #: ____________________

☐ Augmentative and Alternative Communication
Name: ____________________ ph #: ____________________

☐ Vision Services
Name: ____________________ ph #: ____________________

☐ Orientation/Mobility
Name: ____________________ ph #: ____________________

☐ DHH Services
Name: ____________________ ph #: ____________________

☐ Adaptive P.E.
Name: ____________________ ph #: ____________________

☐ Other
Name: ____________________ ph #: ____________________

☐ Occupational Therapy
Name: ____________________ ph #: ____________________

☐ Physical Therapy
Name: ____________________ ph #: ____________________

☐ Counseling
Name: ____________________ ph #: ____________________

☐ Behavior Support
Name: ____________________ ph #: ____________________

☐ California Children Services
Name: ____________________ ph #: ____________________

☐ School site Technology Support Provider
Name: ____________________ ph #: ____________________

☐ Other
Name: ____________________ ph #: ____________________

Describe how the student’s disability affects involvement and progress in the general curriculum. __________________________

What is your objective for making this request?

______________________________________________________________________________________________

Updated May 2013
Medical Considerations:
Please list any medical conditions that affect progress in the general curriculum:
__________________________________________________________________________________________

(Check all that apply)

☐ Has frequent ear infections  ☐ Has frequent upper respiratory infections  ☐ Has digestive problems  ☐
Fatigues easily
☐ Other: Describe briefly: ____________________________________________________________
☐ Currently taking medication, if so, list and describe reason: ________________________________
Vision functioning: ___________________________________________________________
Hearing functioning: ________________________________________________________________

Communication:
Current level of receptive language: ___________________________ Age approximation: _______
If formal tests used, list test and scores, if not, give approximate age or developmental age: __________

Current level of expressive language: __________________________ Age approximation: _______
☐ Speech intelligibility:___________%
If formal tests used, list test and scores, if not, give approximate age or developmental age: __________

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
☐ 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: ☐ tangibles  ☐ pictures  ☐ combination pictures/words  ☐ words
☐ PECS: # of pictures and vocabulary for system:_______________  ☐ TEACCH Schedule
☐ Voice output AC device (Name of device): ________________________________
   Access method:_________________________ (i.e., keyboard, mouse, switch)
☐ Writing: ________________________________
☐ Other: _________________________________

Behavior
Does the student’s behavior impeded learning of self or others?_________________________
If yes, describe behavior and list interventions: __________________________________________