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| **ASSISTIVE TECHNOLOGY (AT) EVALUATION REFERRAL FORM** | **Logo  Description automatically generated** |

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|  |  |  |  |
| **DATE OF REFERRAL** | Click or tap to enter a date. |  |

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| Please ensure the subject line in the email states: **Secure: AT Referral** |

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 **(This should only be the individual’s information)**

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| **Name** | Click or tap here to enter text. |
| **Address** | Click or tap here to enter text. |
|  | Click or tap here to enter text. |
| **Email** | Click or tap here to enter text. |
| **Phone** | Click or tap here to enter text. | [ ]  Cell | [ ]  Landline |
|  | **Can a message be left?** | [ ]  Yes | [ ]  No |

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| **Is there another person that should be contacted for the intake process and scheduling? (Guardian/Family member/Provider Staff)** |  | [ ]  **Yes** | [ ]  **No** |
| **Contact Name** | Click or tap here to enter text. | **Email** | Click or tap here to enter text. |
| **Relationship to Individual** | Click or tap here to enter text. | **Phone** | Click or tap here to enter text. |

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| **Please check all of the domains that the person is interested/would benefit in having greater independence.** |
| [ ]  Communication | [ ]  Daily Living Aids | [ ]  Cognitive Augmentation | [ ]  Computer/Device Use |
| [ ]  Safety | [ ]  Environmental Controls | [ ]  Healthcare/Medication Mgt | [ ]  Transportation |
| [ ]  Employment | [ ]  Organization/Executive Function | [ ]  Social/Emotional Support | [ ]  LV/Blind |
| **Reason for Referral: Brief description can include multiple areas:** | [ ]  HOH/Deaf |
|  |

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| **Is this individual also interested in Remote Supports and Monitoring** | [ ]  Yes | [ ]  No |
| **Who is the preferred provider of Remote Supports and Monitoring** |  |
| **Contact Information of Remote Supports and Monitoring Provider** |  |

**REFERRING DDS SERVICE COORDINATOR:**

|  |  |
| --- | --- |
| **Name** | Click or tap here to enter text. |
| **Title** | Click or tap here to enter text. |
| **DDS Area Office** | Click or tap here to enter text. |
| **Email** | Click or tap here to enter text. |
| **Phone** |  | [ ]  Cell | [ ]  Landline |

**DDS APPROVAL:**

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| **FMIS Authorization Required**  | Number |  |

Area Director or designee review and approval is required prior to sending to AT Provider that the individual selected.

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| **PROVIDER REFERRED TO:** | Choose an item. |
| **DATE REFERRAL SENT:** | Click or tap to enter a date. |

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| **Is an AT Screening Assessment Attached?** | [ ]  YES | [ ]  NO |  | **Is her/his ISP Attached?** | [ ]  YES | [ ]  NO |