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

|  |  |  |
| --- | --- | --- |
|  |  |  |
| **DATE OF REFERRAL** |  | |  | | --- | | Please ensure the subject line in the email states: **Secure: AT Referral** | |

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** |  | | | |
| **Address** |  | | | |
|  |  | | | |
| ***Of the person*** |  | |  | |
|  | **Cell of Guardian** | | Cell | Landline |
|  |  | Call | Text | Email |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Is there another person that should be contacted for the intake process and scheduling? (Guardian/Family member/Provider Staff)** | | | |  | **Yes** | **No** |
| **Contact Name:** |  |  |  | | | |
| **Relationship to Individual: Parent/Guardian** |  | **Phone:** |  | | | |
| **Contact Name:** |  |  |  | | | |
| **Relationship to Individual:** | | **Phone** | | | | |
|  | |  | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Please check all of the domains that the person is interested/would benefit from 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 | | | Low Vision/Blind | |
| **Reason for Referral: A brief description can include multiple areas:** | | | | | HOH/Deaf | |
| **CHOSEN AT PROVIDER: Click Here** | | | | | | |
| **Is this individual also interested in Remote Supports and Monitoring** | | | | Yes | | No |
| **Who is the preferred provider of Remote Supports and Monitoring** | | | Choose an item. | | | |
| **Contact Information of Remote Supports and Monitoring Provider** | | |  | | | |

**REFERRING DDS SERVICE COORDINATOR:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** |  | | |
| **Title** |  | | |
| **DDS Area Office** |  | | |
| **Email** |  | | |
| **Phone** |  | Cell | Landline |

**DDS APPROVAL:**

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

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **DATE REFERRAL SENT:** |  | | | | |
| **Is an AT Screening Assessment Attached?** | | **YES** | NO |  | **Is her/his ISP Attached?** | | YES | NO |