|  |  |
| --- | --- |
| **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** | [x]  Cell  | [ ]  Landline |
|  |  | [x]  Call | [ ]  Text | [ ]  Email |

|  |  |  |  |
| --- | --- | --- | --- |
| **Is there another person that should be contacted for the intake process and scheduling? (Guardian/Family member/Provider Staff)** |  | [x]  **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 |