|  |  |
| --- | --- |
| ***Assistive Technology***  ***SCREENING ASSESSMENT*** | DDS Logo - Picture of State of MA and State Seal |

|  |  |  |
| --- | --- | --- |
| **Name:** | **Date:** | Click or tap to enter a date. |
| **Name of Person Conducting Screening:** | | |

**An AT Screening Assessment should be completed with every individual.**

*(Either this form can be used, or a licensed provider can use a form that covers these topic areas)*

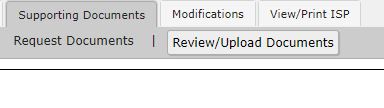
**Who should fill out this form:**

This form should be completed with the individual. The individual’s support team including family, service coordinator and residential/day service providers, if applicable, should be involved.

**Review Process:**

This should be reviewed by ISP Team to:

1. Identify areas that the individual may benefit from AT
2. Identity potential AT devices/tools that the individual may be able to use and accept.
   * Low tech options and/or technology that does not require customization or individualized programing can be acquired without a referral to DDS AT services.
3. Identify AT devices/tools available to borrow to from a Lending Library for the individual to trial using the device.
4. **Determine if a referral for a professional evaluation is recommended**.



**Once Completed:**

The AT Screening Assessment should be uploaded using the Supporting Documents tab and selecting “Other Documents” within the ISP module.*(Documents can be uploaded in the other documents category in HCSIS at any time by both the provider and DDS staff)*

|  |
| --- |
| **A picture of a shaded box for denoting when an AT referral should be sought AT Evaluation Referral is Needed:**   * If the individual needs support in any section that has a **Shaded box checked**, a referral for AT evaluation is recommended. * An individual who is interested in receiving Remote Supports and Monitoring will need a comprehensive AT Evaluation to identify personal goals and address any safety/medical needs, independent living/community areas that have potential risks. * The AT Screening Assessment demonstrates a need for professional AT evaluation beyond what the provider/family/care giver can provide. * An individual has an emergent need and/or significant change in need, a referral can be made for an AT evaluation to be completed to address a specific goal/targeted need(s). * AT that is used to assist the individual with managing health and safety related needs. |

**SECTION 1. COMMUNICATION**

**EXPRESSIVE LANGUAGE:** Expressive language is the ability to be able to relate your thoughts, needs and wishes to another.

**RECEPTIVE LANGUAGE:** Receptive language is the ability to understand words and language.

**AAC:** A type of AT, AAC stands for Alternative & Augmentative Communication, (ex: Proloquo2Go, DynaVox)

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Does the individual use American Sign Language?** | | | | | **Yes  No** | | | | |
| **Does the individual use AAC now?** | | | **Yes: enter their device/tool info below**  **No: this individual currently has no AAC device** | | | | | | |
| **Current Assistive Technology** | |  | | **Is the AT device/tool working?** | | | | **Yes  No** | |
| **Question** | | | | | **Fully Capable**  **No AT Needed** | **Needs support** | | **Has Interest**  **AT option** |
| Gains attention | | | | |  |  | |  |
| Identifies themselves to others | | | | |  |  | |  |
| Request assistance when needed | | | | |  |  | |  |
| Can Provide identifying information: DOB, Address, Telephone Number | | | | |  |  | |  |
| Desires to communicate but cannot communicate or is unintelligible | | | | |  |  | |  |
| Communicates using facial expressions, pointing, etc. | | | | |  |  | |  |
| Takes in information by watching modeled behaviors/ tasks | | | | |  |  | |  |
| Recognizes Communication Symbols or uses pictures to communicate | | | | |  |  | |  |
| Can understand verbal concepts and instructions | | | | |  |  | |  |
| Express and exchange ideas or thoughts with other | | | | |  |  | |  |
| Communicates wants and needs | | | | |  |  | |  |
| Tell someone if they are ill or injured, identify medical needs | | | | |  |  | |  |

**SECTION 2. COMPUTER/TECHNOLOGY ACCESS**

**Computer/ Technology Access** is the ability to use typical computers and technology for such activities as communicating with others, searching the internet, and engaging in a variety of services including telehealth and virtual service delivery.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Does the individual use AT to access?**  Ex. Requires adaptive access to use computer/tablet (adaptive keyboard /mouse/eye-control, etc.) | | | **Yes: enter their device/tool info below**  **No: No: this individual currently has no AT for this area** | | | | |
| **Current Assistive Technology** |  | **Is the AT device/tool working?** | | | | **Yes  No** | |
| **Question** | | | | **Fully Capable**  **No AT Needed** | **Needs support** | | **Has Interest**  **AT option** |
| Interacts with a tablet/cell phone (turn on/off; find apps, etc.) | | | |  |  | |  |
| Is able to access important contacts including doctors. | | | |  |  | |  |
| Can contact others for assistance or to communicate | | | |  |  | |  |
| Is able to text message others and send pictures (this can include using speech to text) | | | |  |  | |  |
| Can access 911 and communicate emergency | | | |  |  | |  |
| Is able to video chat (Zoom, Google Duo, Facetime) | | | |  |  | |  |
| Can access web pages of interest | | | |  |  | |  |
| Knows how to use email | | | |  |  | |  |
| Knows when technology is in use | | | |  |  | |  |
| Uses technology to make purchases | | | |  |  | |  |
| Uses technology to access services such as online banking | | | |  |  | |  |

**SECTION 3.** **LITERACY**

**LITERACY** is the ability to read and write

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Does the individual use AT in this area now?** | | **Yes: enter their device/tool info below**  **No: this individual currently has no AT for this area** | | | | | |
| **Current Assistive Technology** |  | | **Is the AT device/tool working?** | | | **Yes  No** | |
| **Question** | | | | **Fully Capable**  **No AT Needed** | **Needs support** | | **Has Interest**  **AT option** |
| Reads simple words | | | |  |  | |  |
| Understands words/symbols | | | |  |  | |  |
| Understands words/symbols for dangerous household items | | | |  |  | |  |
| Can read & spell at least a 5th grade level | | | |  |  | |  |
| Can write/type words accurately | | | |  |  | |  |

**SECTION 4. COGNITIVE AUGMENTATION/ORGANIZATION**

**COGNITIVE AUGMENTATION/ORGANIZATION** is the ability to stay focused, remember, organize, and task completion.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Does the individual use AT in this area now?** | | | **Yes: enter their device/tool info below**  **No: this individual currently not using AT device/tool** | | | | | |
| **Current Assistive Technology** | |  | | **Is the AT device/tool working?** | | | **Yes  No** | |
| **Question** | | | | **Fully Capable**  **No AT Needed** | **Needs support** | | **Has Interest**  **AT option** |

|  |  |  |  |
| --- | --- | --- | --- |
| Keeps own calendar |  |  |  |
| Can create lists |  |  |  |
| Participates in activities planning |  |  |  |
| Is able to complete all steps required to complete a task |  |  |  |
| Manages necessary reminders |  |  |  |
| Is knowledgeable of all the steps involved in completing a task |  |  |  |

**SECTION 5.** **DAILY LIVING AND ENVIROMENTAL CONTROLS (*Complete if only applies to Work*)**

**DAILY LIVING AND ENVIROMENTAL CONTROLS** is the ability to perform functional skills required to care for oneself and to use the appliances, switches and other controls in one’s environment. ***(Complete only if it applies to work)***

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Does the individual use AT in this area now?** | | **Yes: enter their device/tool info below**  **No: this individual currently not using AT device/tool** | | | | | |
| **Current Assistive Technology** |  | | **Is the AT device/tool working?** | | | **Yes  No** | |
| **Question** | | | | **Fully Capable**  **No AT Needed** | **Needs support** | | **Has Interest**  **AT option** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Personal Care** |  |  |  |
| Brushes teeth/including putting toothpaste on brush |  |  |  |
| Can reach faucet in bathroom sink |  |  |  |
| Can reach and use soap |  |  |  |
| Can bath and shower |  |  |  |
| Put on/take off clothes |  |  |  |
| Can put on/take off shoes |  |  |  |
| Can select appropriate clothing |  |  |  |
| **MEAL PREP** |  |  |  |
| Mix, chop, cut |  |  |  |
| Set the table |  |  |  |
| Can Pour |  |  |  |
| Can cook and use stove safely |  |  |  |
| Reach food in cabinets and refrigerator |  |  |  |
| Can follow a written recipe |  |  |  |
| Uses appliances safely and appropriately |  |  |  |
| **ENVIROMENTAL CONTROLS** |  |  |  |
| Dust |  |  |  |
| Vacuum |  |  |  |
| Laundry |  |  |  |
| Turn on TV/change channels |  |  |  |
| Load dishwasher/wash dishes |  |  |  |
| Turn on/off lights |  |  |  |
| Open/close shades |  |  |  |

**SECTION 6. DAILY LIVING AND ENVIROMENTAL CONTROLS**

**HEALTH AND MEDICATION MANAGEMENT** is the ability to manage one’s health care needs and self-administer medications.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Does the individual use AT in this area now?** | | **Yes: enter their device/tool info below**  **No: this individual currently not using AT device/tool** | | | | | | |
| **Current Assistive Technology** |  | | **Is the AT device/tool working?** | | | **Yes  No** | | |
| **Question** | | | | **Fully Capable**  **No AT Needed** | **Needs support** | | **Has Interest**  **AT option** |

|  |  |  |  |
| --- | --- | --- | --- |
| Is the individual able to self-medicate  (Meets self-medicating criteria  **Yes  No**) |  |  |  |
| Is able to dispense their medication |  |  |  |
| Is able to manage health care conditions |  |  |  |
| Is able to contact Health Care Practitioner(s) |  |  |  |

**SECTION 7.** **RECREATION, LEISURE AND SOCIAL EMOTIONAL SUPPORT AND CYBER SECURITY**

**RECREATION, LEISURE AND SOCIAL EMOTIONAL SUPPORT** is the ability to engage in meaningful activities, and safely stay connected with others and be inclusive in their community. ***(Complete only if it applies to work)***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Does the individual use AT in this area now?** | | **Yes: enter their device/tool info below**  **No: this individual currently not using AT device/tool** | | |
| **Current Assistive Technology** |  | | **Is the AT device/tool working?** | **Yes  No** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Question** | **Fully Capable**  **No AT Needed** | **Needs support** | **Has Interest**  **AT option** |
| Can participate in sporting activities such as golf, basketball, fishing, etc. |  |  |  |
| Can use gaming systems and connect with others online |  |  |  |
| Can complete crafts |  |  |  |
| Can use electronics (TV, Phone, etc) to watch shows, play music, etc. |  |  |  |
| Can use strategies or will reach out to others for emotional support |  |  |  |
| Understands Internet safety |  |  |  |
| Understand what they should share over the internet |  |  |  |

**SECTION 8.** **T RANSPORTATION**

**TRANSPORTATION** is the ability to use transportation options and/or navigate independently in the community.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Does the individual use AT in this area now?** | | **Yes: enter their device/tool info below**  **No: this individual currently not using AT device/tool** | | |
| **Current Assistive Technology** |  | | **Is the AT device/tool working?** | **Yes  No** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Question** | **Fully Capable**  **No AT Needed** | **Needs support** | **Has Interest**  **AT option** |
| Can walk to destination |  |  |  |
| Uses transportation to get to destination (Drives, Bus, Subway, Uber, etc) |  |  |  |

**SECTION 9. EMPLOYMENT**

**Employment** is the ability to completes all the job functions required for a particular position.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Does the individual use AT in this area now?** | | **Yes: enter their device/tool info below**  **No: this individual currently not using AT device/tool** | | |
| **Current Assistive Technology** |  | | **Is the AT device/tool working?** | **Yes  No** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Question**  ***(Write a list of the different tasks a person needs to complete in their job, such as pricing item, load on shelf, inventory count, etc)*** | **Fully Capable**  **No AT** | **Needs support** | **Has Interest**  **AT option** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |