|  |  |
| --- | --- |
|  ***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 |[ ] [ ] [x]
| 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** [x]  **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** |
|  | [ ]  | [ ]  | [ ]  |
|  | [ ]  | [ ]  | [ ]  |
|  | [ ]  | [ ]  | [ ]  |