

# Assistive Technology Extended Assessment Plan

Date of Extended Assessment Planning: \_\_\_\_\_

Student Data	
Student Name	_____
Parent Name(s)	_____
Parent Phone	_____
Parent Email	_____
Parent Address	_____
	_____
Date of Birth	_____ CA _____
Disability	_____
IEP Date	_____
Medicaid ID#	_____
Medical Diagnosis	_____
Social Security #	_____
Grade/Placement	_____
Student #	_____
School	_____
School Address	_____
	_____
School Phone	_____
School Fax	_____

Team Members	
<u>AT Extended Assessment Coordinator</u>	
Name	_____
Title	_____
Phone	_____
Email	_____
Other Team Members	
Name	_____ Title _____
Phone	_____
Email	_____
Name	_____ Title _____
Phone	_____
Email	_____
Name	_____ Title _____
Phone	_____
Email	_____

## Overall Goal for Device Use

Goal for Student's Use of the Device:

\_\_\_\_\_

How will we know if the trial is successful?

\_\_\_\_\_

What level of achievement is reasonable to expect during the trial period?

\_\_\_\_\_

How will we know if the trial is not working (What criteria will we use to stop)?

\_\_\_\_\_

## Customary Environments Where Devices Will Be Used

1. Environment: \_\_\_\_\_  
Tasks: \_\_\_\_\_  
Person responsible for implementation: \_\_\_\_\_  
Days to be used: \_\_\_\_\_  
Times to be used: \_\_\_\_\_
  
2. Environment: \_\_\_\_\_  
Tasks: \_\_\_\_\_  
Person responsible for implementation: \_\_\_\_\_  
Days to be used: \_\_\_\_\_  
Times to be used: \_\_\_\_\_
  
3. Environment: \_\_\_\_\_  
Tasks: \_\_\_\_\_  
Person responsible for implementation: \_\_\_\_\_  
Days to be used: \_\_\_\_\_  
Times to be used: \_\_\_\_\_

## Specific Devices For Trial

**Device #1** \_\_\_\_\_  
Date of trial Initiation \_\_\_\_\_ Minimum length of trial period \_\_\_\_\_  
Device trial review date \_\_\_\_\_  
Source of Device for Trial \_\_\_\_\_  
Contact person for technical assistance for trial \_\_\_\_\_  
Manufacturer: \_\_\_\_\_ Manufacturer technical assistance number \_\_\_\_\_  
Comments

**Device #2** \_\_\_\_\_  
Date of trial Initiation \_\_\_\_\_ Minimum length of trial period \_\_\_\_\_  
Device trial review date \_\_\_\_\_  
Source of Device for Trial \_\_\_\_\_  
Contact person for technical assistance for trial \_\_\_\_\_  
Manufacturer: \_\_\_\_\_ Manufacturer technical assistance number \_\_\_\_\_  
Comments

**Device #3** \_\_\_\_\_  
Date of trial Initiation \_\_\_\_\_ Minimum length of trial period \_\_\_\_\_  
Device trial review date \_\_\_\_\_  
Source of Device for Trial \_\_\_\_\_  
Contact person for technical assistance for trial \_\_\_\_\_  
Manufacturer: \_\_\_\_\_ Manufacturer technical assistance number \_\_\_\_\_  
Comments

**Extended Assessment Summary**  
(To be completed at the end of the assessment)

- How did the child's performance change when using the devices?
  
- How did the student like using each device? Did the student prefer one of the devices?
  
- What are the advantages of using the devices?
  
- What are the disadvantages of using the devices?
  
- How long can the child be expected to use the devices?

**Extended Assessment Team Recommendation:**