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

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|  |  |  |  |
| **DATE OF REFERRAL** | Click or tap to enter a date. |  | |  | | --- | | Please ensure the subject line in the email states: **Secure: AT Referral** | |

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

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | Click or tap here to enter text. | | |
| **Address** | Click or tap here to enter text. | | |
|  | Click or tap here to enter text. | | |
| **Email** | Click or tap here to enter text. | | |
| **Phone** | Click or tap here to enter text. | Cell | Landline |
|  | **Can a message be left?** | Yes | No |

|  |  |  |  |  |  |  |
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| **Is there another person that should be contacted for the intake process and scheduling? (Guardian/Family member/Provider Staff)** | | | |  | **Yes** | **No** |
| **Contact Name** | Click or tap here to enter text. | **Email** | Click or tap here to enter text. | | | |
| **Relationship to Individual** | Click or tap here to enter text. | **Phone** | Click or tap here to enter text. | | | |

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| --- | --- | --- | --- |
| **Please check all of the domains that the person is interested/would benefit in 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 | LV/Blind |
| **Reason for Referral: Brief description can include multiple areas:** | | | HOH/Deaf |
|  | | | |

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| --- | --- | --- | --- |
| **Is this individual also interested in Remote Supports and Monitoring** | | Yes | No |
| **Who is the preferred provider of Remote Supports and Monitoring** |  | | |
| **Contact Information of Remote Supports and Monitoring Provider** |  | | |

**REFERRING DDS SERVICE COORDINATOR:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | Click or tap here to enter text. | | |
| **Title** | Click or tap here to enter text. | | |
| **DDS Area Office** | Click or tap here to enter text. | | |
| **Email** | Click or tap here to enter text. | | |
| **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.

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| **PROVIDER REFERRED TO:** | Choose an item. | | |
| **DATE REFERRAL SENT:** | | Click or tap to enter a date. |

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