AZEIP ASSISTIVE TECHNOLOGY REFERRAL PACKET

INSTRUCTIONS

Prior to the completion of the AzEIP Assistive Technology Referral Packet:

- Explore low-tech AT options and Durable Medical Equipment (DME)
- Explore all available funding sources *(e.g. health plan, community resources)*
- AT services and supports must be discussed with all core team members
- Suggestion: Invite Southwest Human Development (SWHD) to the team meeting to staff AT prior to adding to Individualized Family Service Plan (IFSP)

REQUIRED REFERRAL PACKET DOCUMENTS

☐ IFSP: Attach a copy of the most recent IFSP. IFSP outcomes and strategies must directly relate to the need for AT. The planned start date for the AT Assessment must be dated 30 days from the date of the IFSP.

☐ Insurance: Attach a legible copy of any third-party Consent to bill insurance

☐ Eligibility Evaluation(s)

☐ Current Quarterly Reports

PACKET MUST BE COMPLETED IN ITS ENTIRETY OR THE PROCESS WILL BE DELAYED

Send completed packets within 48 hours of adding AT to the IFSP to:

EMAIL: ccanivez@swhd.org

FAX: 602-633-8410

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Date SWHD Received Referral Packet: _____

Date EIP sent referral: _____ AT Assessment Planned Start Date: _____

If the child has had an AT Assessment within the last 3 months, contact SWHD.

If the child has never had an AT Assessment or it has been 6 months or longer since his/her AT Assessment, all sections below must be filled out.

CLIENT INFORMATION

Child's Name *(Last. First)* _____ Date of Birth _____

Parent Name *(Last, First)* _____

Home Address *(No., Street)* _____

City _____ State _____ ZIP Code _____

Primary Language _____

CIF/ASSIST ID # _____ FOCUS ID # _____ ITEAMS ID # _____

Eligibility *(Check all that apply)*:

☐ AzEIP *(Arizona Early Intervention Program)* ☐ DDD *(Division of Developmental Disability)*

☐ ALTCS *(Arizona Long Term Care System)* ☐ ASDB *(Arizona School for the Deaf and Blind)*

Primary Diagnosis: _____

Secondary Diagnosis: _____

Additional medical information *(TBI, seizures, hospitalizations, etc)*:

AZEIP TEAM INFORMATION

Agency Name		
	SERVICE COORDINATOR	**TEAM LEAD**
Name		
Mailing Address		
Email Address		
Phone		
Fax #		

AZEIP TEAM MEETING INFORMATION

Location:		
Day of Week *(select one)*: ○ M ○ T ○ W ○ TH ○ F	Time:	Call in Number:

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IFSP INFORMATION

List the existing IFSP outcome(s) that an AT Assessment or device is needed for.

DESCRIBE THE CHILD'S PHYSICAL DEVELOPMENT						
Ability to hold head up	○ Good		○ Fair		○ Poor	
Ability to sit without support	○ Good		○ Fair		○ Poor	
Muscle tone in arms/legs	○ Floppy	○ Average	○ Stiff		○ Varies	
Muscle tone in arms/hands	○ Floppy	○ Average	○ Stiff		○ Varies	
Ability to use hands	○ Unable	○ Right Only	○ Left Only	○ Limited	○ No Difficulty	
Walking ability	○ Not At All		○ Inconsistent		○ Consistent	
Balance	○ Steady	○ Fair	○ Poor		○ Falls Frequently	
Other:						

LIST ALL MEDICAL OR ASSISTIVE DEVICES THAT HAVE BEEN TRIALED *(LOW TO HIGH TECH)*			
DEVICE	**BRAND/TYPE**	**SETTING**	**OUTCOME**

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ADDITIONAL INFORMATION *(FOOD ALLERGIES, RESPIRATION CONCERNS, FEEDING/SWALLOWING, SENSORY, RESISTANCE TO USING DEVICES)*

DESCRIBE THE CHILD'S LANGUAGE DEVELOPMENT

Present communication ability *(check all that apply)*:			
☐ Complete Words	☐ Incomplete Words	☐ Vocalizations	☐ Gestures
☐ Sign Language	☐ Eye Gaze	☐ Communication Device	☐ Facial Expressions
☐ Other:			
Responds to Communication	○ Not at All	○ Inconsistent	○ Consistent
Gains Attention	○ Not at All	○ Inconsistent	○ Consistent
Expresses Wants and Needs	○ Not at All	○ Inconsistent	○ Consistent
Follows Simple Directions	○ Not at All	○ Inconsistent	○ Consistent
Asks Questions	○ Not at All	○ Inconsistent	○ Consistent
Recognizes/Discriminates Systems and/or Pictures	○ Not at All	○ Inconsistent	○ Consistent