



### ***Instructions for Completion of AAC Paperwork***

1. Enclosed are our intake questionnaires for the *Case Manager, Parent, Nurse, Teacher, Speech Therapist, and OT/PT*. **Please have each discipline complete their own questionnaire, sign and return.** Please duplicate the pages as needed.
2. The enclosed "Agreement of Report" must be completed and signed by the ***Director of Special Services***.
3. Please send a copy of the following documents along with the intake questionnaires:
  - A copy of the student's IEP
  - A copy of all educational, social, psychological, speech, neurological and medical
4. Please assemble all of the paperwork and **send it to us at the same time.**

### ***How to Return the Paperwork to BCSS***

**Fax:** (201) 291-0492  
**Attn:** Michel Romeo

**Email:** [aacdept@bergen.org](mailto:aacdept@bergen.org)  
**Attn:** Michele Romeo

**Mail:** AAC Department 3rd Floor  
Bergen County Special Services  
540 Farview Ave; 3<sup>rd</sup> Floor  
Paramus, NJ 07652



## ***Agreement of Report Request***

Student Name: \_\_\_\_\_

Thank you for requesting an Augmentative Communication Assessment with Educational Enterprises/Bergen County Special Services. Please acknowledge your understanding that we will provide an Augmentative Communication Educational Report, as described below.

*An Augmentative Communication Educational Report will detail communication need within the educational environment. It will provide information in regards to the student's ability to make requests, have wants and needs met, to communicate interactively and use communication functionally within the educational environment. The report includes a rationale for the assessment, student profile, observation within the natural setting if deemed necessary, assessment, summary, recommended goals, and recommended device/equipment if applicable. Upon completion of the report, it will be sent to the Director of Special Services. Funding for recommended communication devices/equipment is typically provided by the student's school district. Bergen County Special Services does not provide medical/funding reports.*

*Please check box and sign acknowledgement of the type of report that will be provided.*

I acknowledge that Bergen County Special Services/Educational Enterprises will provide an Augmentative Communication Educational Report.

Administrator Authorization (Signature Required): \_\_\_\_\_

Print Name: \_\_\_\_\_

**Augmentative/Alternative Communication  
Intake Questionnaire**

**CASE MANAGER**

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**Student Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **DOB:** \_\_\_\_\_  
**Case Manager:** \_\_\_\_\_ **Email:** \_\_\_\_\_  
**School:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**1. Education**

**History/Current Placement**

Did the student receive Early Intervention Services?  Yes  No

- Providing Agency: \_\_\_\_\_
- Services Provided: \_\_\_\_\_
- Duration of Services: \_\_\_\_\_

**Prior Academic Programs (Name, Location, Dates Attended)**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**Current Program**

**Name:** \_\_\_\_\_

**Location:** \_\_\_\_\_

**Date of Entrance:** \_\_\_\_\_

**Brief Description of Program:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current Direct Services (Check all that apply & provide frequency)**

- Speech/Language Therapy \_\_\_\_\_
- Occupational Therapy \_\_\_\_\_
- Physical Therapy \_\_\_\_\_
- Behavioral Therapy \_\_\_\_\_
- Consultation (Type) \_\_\_\_\_
- Commission for the Blind \_\_\_\_\_
- Other \_\_\_\_\_

## 2. Medical

### *History/Current Status*

*Please include Diagnosis, date of diagnosis, place diagnosis was made, as well as the doctor who made the diagnosis (Please attach report)*

- Cerebral Palsy \_\_\_\_\_
- Down's Syndrome \_\_\_\_\_
- TBI \_\_\_\_\_
- Autism \_\_\_\_\_
- Other \_\_\_\_\_

Does the student have any type of prosthetic implants (i.e. shunts, pacemaker?)

Yes  No

If yes, please explain:

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Does the student have a seizure disorder?  Yes  No

If yes, please describe (type of seizure, triggers, etc.):

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Does the student have allergies?  Yes  No

If yes, please list allergies:

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### 3. What would you like to see as a result of this AAC Evaluation?

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*If there is any other information you would like to share, please use the space on the back of this paper. The AAC team greatly appreciates your filling out this questionnaire.*

Case Manager Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Augmentative/Alternative Communication  
Intake Questionnaire**

**PARENT**

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Your input is extremely important. Please complete the form below and return the form to your child's Case Manager prior to the AAC evaluation meeting.

**Name of Person Completing Form:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Name of Student:** \_\_\_\_\_  
**Age & DOB of Student:** \_\_\_\_\_

**1. Name of Parents/Guardians**

\_\_\_\_\_  
\_\_\_\_\_

**2. Name and age of Siblings**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**3. How does the child communicate at home/community?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**4. What does the child communicate at home/community?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**5. Who does the child communicate with most frequently?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**6. Is your child using an AAC device?**  Yes  No

- If yes, please name the system being used: \_\_\_\_\_
- If yes, does your child have free access to this system at all times?  Yes  No
- Does he/she use the AAC independently?  Yes  No

**7. Please list your child's interests:**

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**8. Where does the child enjoy spending free time?**

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**9. What would you like to see as a result of the AAC evaluation?**

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**10. Please give a quick overview of your child's medical history  
(Doctor/Date/Location)**

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**11. Educational/Therapeutic: (Please include details regarding Early  
Intervention, Homebound Therapies, Schools your child has attended)**

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Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Augmentative/Alternative Communication  
Intake Questionnaire**

**NURSE**

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**Student Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **DOB:** \_\_\_\_\_  
**Nurse Name:** \_\_\_\_\_ **Email:** \_\_\_\_\_  
**School:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**1. Medical**

***History/Current Status***

*Please include Diagnosis, date of diagnosis, place diagnosis was made, as well as the doctor who made the diagnosis (Please attach report)*

- Cerebral Palsy \_\_\_\_\_
- Down's Syndrome \_\_\_\_\_
- TBI \_\_\_\_\_
- Autism \_\_\_\_\_
- Other \_\_\_\_\_

Does the student have any type of prosthetic implants (i.e. shunts, pacemaker?)

Yes  No

If yes, please explain:

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Does the student have a seizure disorder?  Yes  No

If yes, please describe (type of seizure, triggers, etc.):

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Does the student have allergies?  Yes  No

If yes, please list allergies:

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**2. Vision Impairment(s)**

Does the student have a visual impairment?  Yes  No

If yes, please describe and include diagnosis, date of diagnosis & doctor:

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Does the student have a Nystagmus/Strabismus?  Yes  No

Does the student wear glasses?  Yes  No

- What is the student's acuity with glasses? \_\_\_\_\_

Does the student wear a bifocal?  Yes  No

Does the student have CVI (Cortical Visual Impairment)?  Yes  No

**3. Hearing Impairment**

Does the student have hearing impairment?  Yes  No

If yes, please describe and include diagnosis, date of diagnosis & doctor:

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What is the date of the most recent hearing screening/test? \_\_\_\_\_

- What were the results of the last Audiological?  
\_\_\_\_\_

Does the student have any of the following:

- Hearing Aids
- FM System
- Cochlear Implant

*If there is any other information you would like to share, please use the space on the back of this paper. The AAC team greatly appreciates your filling out this questionnaire.*

Nurse Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Augmentative/Alternative Communication  
Intake Questionnaire**

**TEACHER**

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**Student Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **DOB:** \_\_\_\_\_  
**Teacher:** \_\_\_\_\_ **Email:** \_\_\_\_\_  
**School:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**1. Academics**

*Briefly describe the student's skills as they relate to each of the following areas:*

**Reading:**

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**Spelling:**

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**Writing:**

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What is the student's cognitive level?  Concrete  Abstract

***The student demonstrates understanding of: (Check all that apply)***

- |   |   |
|---|---|
| <input type="checkbox"/> Cause/Effect   | <input type="checkbox"/> Sequencing                       |
| <input type="checkbox"/> Categorization | <input type="checkbox"/> Symbolic Representation          |
| <input type="checkbox"/> Associations   | <input type="checkbox"/> Yes/No                           |
| <input type="checkbox"/> "wh" questions | <input type="checkbox"/> Object to Picture Correspondence |

Does the student follow directives? (Please describe)

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Does the student work independently?  Yes  No

## 2. Assistive Technology

Does the student's physical impairment interfere with his/her ability to access technology? (i.e. computer, augmentative devices, iPad, etc.)  Yes  No

Please indicate if any of these technologies are being used with the student:

- Computer       SmartBoard/Mimio Board  
 iPad             Switches

How does the student currently access technology? Please describe:

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Has an Assistive Technology Evaluation been completed in order to determine if switch access is necessary?  Yes  No

If yes, please provide date and assessment recommendations:

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If a switch is being used to assist the student in accessing technology, what is the name of the switch being used? \_\_\_\_\_

- How long has the student been using the switch? \_\_\_\_\_

What is the student's most reliable access site?

- Head    Chin    Arm    Hand    Knee    Foot    Eye Gaze  
 Other (*Describe*) \_\_\_\_\_

If the student's motor impairment interferes with controlled movement of the above-mentioned access sites, what other forms of access have been trialed? (i.e. eye gaze) *Please explain:*

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**3. Behavioral**

Does the student demonstrate behavioral difficulties?  Yes  No

If yes, please explain:

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Is there a behavioral plan (e.g. token board visual schedule)?  Yes  No

If yes, please describe

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**4. Interests**

Please list the student's interests:

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**5. What would you like to see as a result of this AAC Evaluation**

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*If there is any other information you would like to share, please use the space on the back of this paper. The AAC team greatly appreciates your filling out this questionnaire.*

Teacher Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Augmentative/Alternative Communication  
Intake Questionnaire**

**Speech Therapy**

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**Student Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **DOB:** \_\_\_\_\_  
**SLP Name:** \_\_\_\_\_ **Email:** \_\_\_\_\_  
**School:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**1. Education**

*Current Direct Services (Please Provide Frequency)*

Speech/Language Therapy \_\_\_\_\_

**2. Academics**

*Briefly describe the student's skills as they relate to each of the following areas:*

**Reading:**

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**Spelling:**

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**Writing:**

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What is the student's cognitive level?  Concrete  Abstract

**The student demonstrates understanding of: (Check all that apply)**

- |   |   |
|---|---|
| <input type="checkbox"/> Cause/Effect   | <input type="checkbox"/> Sequencing                       |
| <input type="checkbox"/> Categorization | <input type="checkbox"/> Symbolic Representation          |
| <input type="checkbox"/> Associations   | <input type="checkbox"/> Yes/No                           |
| <input type="checkbox"/> "wh" questions | <input type="checkbox"/> Object to Picture Correspondence |

Does the student follow directives? (Please describe)

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Does the student work independently?  Yes  No

### 3. Hearing Impairment

Does the student have hearing impairment?  Yes  No

If yes, please describe and include diagnosis, date of diagnosis & doctor:

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What is the date of the most recent hearing screening/test? \_\_\_\_\_

• What were the results of the last Audiological? \_\_\_\_\_

Does the student have any of the following:

- Hearing Aids
- FM System
- Cochlear Implant

Does the student demonstrate a startle reflex?  Yes  No

Does the student localize toward sound?  Yes  No

Does the student demonstrate sensitivity to sound?  Yes  No

### 4. Communication

Please check all pre-linguistic skills that apply:

- Joint Attention       Turn-Taking
- Attending to Task       Cause & Effect
- Visual attention       Auditory attention
- Communicative Intent

Is the student motivated to interact with their environment?  Yes  No  Sometimes

Is the student motivated to interact with others?  Yes  No  Sometimes

How is the student currently communicating?

Verbal (one word, two word, three word, other)

• Intelligibility:

○ Familiar person with context \_\_\_\_\_%

○ Unfamiliar person without context \_\_\_\_\_%

Signs/ASL

Gestures

Pointing

Facial Expressions

Reaching

Body Posturing

Eye Gaze

Brings desired item to person or person to item

Picture Communication Books/Boards

Picture Exchange Communication System (PECS)

AAC Device

Does the student initiate communication:

Independently (with who?) \_\_\_\_\_

With prompt (with who?) \_\_\_\_\_

Communicates for purpose of: (Please check all that apply)

Requesting

Interaction

Gain Information

Share Information

Question

Humor/Teasing

Talk about *current* events

Talk about *past* events

Talk about *future* events

\*\*\*If student is currently accessing an *AAC device*, please complete the following\*\*\*

• Name of Device: \_\_\_\_\_

• Describe mode of access with current AAC device:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

• Please list any previously used or trialed AAC Devices

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## 5. Interests

Please list the student's interests:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**6. What would you like to see as a result of this AAC Evaluation**

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*If there is any other information you would like to share, please use the space on the back of this paper. The AAC team greatly appreciates your filling out this questionnaire.*

SLP Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Augmentative/Alternative Communication  
Intake Questionnaire**

**OT/PT**

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**Student Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **DOB:** \_\_\_\_\_  
**OT Name:** \_\_\_\_\_ **Email:** \_\_\_\_\_  
**PT Name:** \_\_\_\_\_ **Email:** \_\_\_\_\_  
**School:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

### 1. Physical Profile

Is a motor impairment present?  Yes  No

- Is the student ambulatory?  Yes  No
- Does the student use a wheelchair?  Yes  No  
If yes, what type of the wheelchair? \_\_\_\_\_
  - Check which wheelchair adaptive features the student uses:
    - Head Support  Trunk Support
    - Strapped Foot Rest  Seatbelt
    - Lap Tray  Arm Positioning Adductor Pad
    - Other \_\_\_\_\_
- Student's general body tone at **rest** is:  
 Hypotonic  Hypertonic  Athetoid  Mixed
- Student's general body tone **during activities**:  
 Hypotonic  Hypertonic  Athetoid  Mixed
- Does the student fatigue easily during motor tasks?  Yes  No
- Does the student have reflex patterns that interfere with voluntary control?  Yes  No
- Can the student move his/her head in a controlled motion?  Yes  No
- Does the student have limited range of motion?  Yes  No

- Does the student have limited use of upper extremities?  Yes  No  
If yes, please explain:

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- Does the student have full mobility of their hands?  Yes  No
  - Dominant hand:  Right  Left
  - Can the student isolate their index finger?  Yes  No
  - Can the student hold and release objects at will?  Yes  No

- Can the student cross midline?  Yes  No

- Is the student on a sensory diet?  Yes  No  
If yes, please describe:

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## 2. Assistive Technology

Does the student's physical impairment interfere with his/her ability to access technology? (i.e. computer, augmentative devices, iPad, etc.)  Yes  No

Please indicate if any of these technologies are being used with the student:

- Computer  SmartBoard/Mimio Board
- iPad  Switches

How does the student currently access technology? Please describe:

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Has an Assistive Technology Evaluation been completed in order to determine if switch access is necessary?  Yes  No

If yes, please provide date and assessment recommendations:

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If a switch is being used to assist the student in accessing technology, what is the name of the switch being used? \_\_\_\_\_

- How long has the student been using the switch? \_\_\_\_\_

What is the student's most reliable access site?

Head  Chin  Arm  Hand  Knee  Foot  Eye Gaze

Other (*Describe*) \_\_\_\_\_

If the student's motor impairment interferes with controlled movement of the above-mentioned access sites, what other forms of access have been trialed? (i.e. eye gaze) *Please explain:*

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### 3. Vision Impairment(s)

Does the student have a visual impairment?  Yes  No

If yes, please describe:

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Does the student have a Nystagmus/Strabismus?  Yes  No

Does the student wear glasses?  Yes  No

- What is the student's acuity with glasses? \_\_\_\_\_

Does the student wear a bifocal?  Yes  No

Does the student have CVI (Cortical Visual Impairment)?  Yes  No

Is the student's vision consistent across environments and time of day?

Yes  No

If no, please explain

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Does the student visually track/follow objects?  Yes  No

Does the student accurately reach toward desired items?  Yes  No

In what position should objects be placed for the student to optimally fixate on it? \_\_\_\_\_

Is the student receiving consultative services from the N.J. Commission for the Blind and Visually Impaired?  Yes  No

Please provide input regarding the following:

- Optimal distance between student and visual stimuli \_\_\_\_\_
- Optimal color contrast on visual stimuli \_\_\_\_\_
- Optimal size of visual stimuli \_\_\_\_\_
- Modifications being used to enhance visual acuity \_\_\_\_\_

Does the student indicate a visual preference to: (Check all that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> Photographs                  | <input type="checkbox"/> Objects                           |
| <input type="checkbox"/> Line Drawings                | <input type="checkbox"/> Typed Words                       |
| <input type="checkbox"/> Black & White Visual Stimuli | <input type="checkbox"/> Typed Words & Symbols             |
| <input type="checkbox"/> Colored Stimuli              | <input type="checkbox"/> Dead zones between visual stimuli |
| <input type="checkbox"/> Photographs                  | <input type="checkbox"/> Increased print size              |
| <input type="checkbox"/> Screen Brightness            |  |

#### 4. Interests

Please list the student's interests:

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#### 5. What would you like to see as a result of this AAC Evaluation

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*If there is any other information you would like to share, please use the space on the back of this paper. The AAC team greatly appreciates your filling out this questionnaire.*

OT Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PT Signature: \_\_\_\_\_ Date: \_\_\_\_\_