Bergen County Special Services
Bergen County Technical Schools
Bergen One-Stop Career Center

BERGEN COUNTY TECHNICAL SCHOOLS / SPECIAL SERVICES

ASSISTIVE TECHNOLOGY/AUGMENTATIVE COMMUNICATION

540 Farview Avenue, 3rd Floor, Paramus, NJ 07652 ● Tel. (201) 343-6000 ext. 6530/6501 ● Fax (201) 291-0492 ● www.bergen.org/ee

Grisel Espinosa
Supervisor

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: **Betsy Reeves**

Email: **betree@bergen.org**
Attn: **Betsy Reeves**

Mail: **Betsy Reeves**
Bergen County Special Services
540 Farview Ave; 3rd Floor
Paramus, NJ 07652

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Grisel Espinosa
Supervisor

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: _____

Bergen County Special Services • Educational Enterprises

Augmentative/Alternative Communication
Intake Questionnaire

CASE MANAGER

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:

_____
_____
_____

Does the student have a seizure disorder? ☐ Yes ☐No
If yes, please describe (type of seizure, triggers, etc.):

_____
_____
_____

Does the student have allergies? ☐ Yes ☐No
If yes, please list allergies:

_____
_____
_____

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

_____
_____
_____

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: _____

Bergen County Special Services • Educational Enterprises

Augmentative/Alternative Communication
Intake Questionnaire

PARENT

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:

_____
_____
_____

8. Where does the child enjoy spending free time?

_____
_____
_____

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

_____
_____
_____

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

_____
_____
_____

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

_____
_____
_____

Parent Signature: _____ Date: _____

Augmentative/Alternative Communication
Intake Questionnaire

NURSE

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:

_____
_____
_____

Does the student have a seizure disorder? ☐ Yes ☐No
If yes, please describe (type of seizure, triggers, etc.):

_____
_____
_____

Does the student have allergies? ☐ Yes ☐No
If yes, please list allergies:

_____
_____
_____

2. Vision Impairment(s)

Does the student have a visual impairment? ☐ Yes ☐No
If yes, please describe and include diagnosis, date of diagnosis & doctor:

_____
_____
_____

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:

_____
_____
_____

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

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:

_____
_____
_____

Spelling:

_____
_____
_____

Writing:

_____
_____
_____

What is the student's cognitive level? ☐ Concrete ☐Abstract

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

- ☐ Cause/Effect
- ☐ Categorization
- ☐ Associations
- ☐ "wh"questions
- ☐ Sequencing
- ☐ Symbolic Representation
- ☐ Yes/No
- ☐ Object to Picture Correspondence

Does the student follow directives? (Please describe)

_____
_____
_____

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:

_____
_____
_____

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:

_____
_____
_____

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:*

_____
_____
_____

3. Behavioral

Does the student demonstrate behavioral difficulties? ☐ Yes ☐No
If yes, please explain:

_____
_____
_____

Is there a behavioral plan (e.g. token board visual schedule)? ☐ Yes ☐No
If yes, please describe

_____
_____
_____

4. Interests

Please list the student's interests:

_____
_____
_____

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

_____
_____
_____

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: _____

Bergen County Special Services • Educational Enterprises

Augmentative/Alternative Communication
Intake Questionnaire

Speech Therapy

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:

_____
_____
_____

Spelling:

_____
_____
_____

Writing:

_____
_____
_____

What is the student's cognitive level? ☐ Concrete ☐Abstract

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

☐ Cause/Effect
☐ Categorization
☐ Associations
☐ "wh"questions
☐ Sequencing
☐ Symbolic Representation
☐ Yes/No
☐ Object to Picture Correspondence

Does the student follow directives? (Please describe)

_____

_____

_____

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:

_____

_____

_____

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)

- Intelligiblity:
  - 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

_____

_____

_____

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

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:

  _____
  _____
  _____

- 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:

  _____
  _____
  _____

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:

_____
_____
_____

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:

_____
_____
_____

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:*

_____
_____
_____

3. Vision Impairment(s)

Does the student have a visual impairment? ☐ Yes ☐No
If yes, please describe:

_____
_____
_____

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

_____
_____
_____

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)

☐ Photographs
☐ Line Drawings
☐ Black & White Visual Stimuli
☐ Colored Stimuli
☐ Photographs
☐ Screen Brightness
☐Objects
☐Typed Words
☐Typed Words & Symbols
☐Dead zones between visual stimuli
☐Increased print size

4. Interests

Please list the student's interests:

_____
_____
_____

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

_____
_____
_____

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: _____