Assistive Technology Infusion Project Round 4

Student Identification

District of Residence IRN#:
Contact Last Name:
Student Date of Birth:
Student's Primary Disability:
School/Program Attending:
Service Location:

Age: 6/29/0006
Sex:
Grade:

District of Residence

IRN#:
District:
County:
Address:
City, State Zip:

District Contact

Name:
Title:
Facility:
Address:
City, State Zip:
Phone:
Fax:
Email:

Superintendent

Name:
Title:
Facility:
Address:
City, State Zip:
Phone:
Fax:
Email:

Building Contact

Name:
Title:
Facility:
Address:
City, State Zip:
Phone:
Fax:
Email:

Treasurer

Name:
Title:
Facility:
Address:
City, State Zip:
Phone:
Fax:
Email:

Assistive Technology Items Requested

1	-
2	-
3	-
4	-
5	-
6	-
7	
8	
9	
10	
11	
12	

Primary category of this technology:

Total Funding Requested:

I. Problem Identification

A. Present Level of Performance

Summarize this student's abilities as they relate to educational/developmental performance and the techniques used for gathering this information. Please do not use the student's name.

B. Statement of Critical Need

Indicate the specific educational and/or developmental needs for this individual student, including the specific tasks that you expect the student to do within the educational program and the environments where these tasks will be completed. **Please do not use the student's name.**

C. Past and Current Accommodations/Modifications

Discuss past and current modifications and/or accommodations, including how long these have been in place, and why or why not these are effective. Please do not use the student's name. This section is optional for applications requesting a total of $3,000 or less.

II. Solution Generation

D. Feature Match

List the assistive technology features that match the identified needs of the student. Discuss those features in terms of the student's ability to use these features. **Please do not use the student's name.**

E. Continuum of Options and Trial Use

List the assistive technologies that were considered in meeting the student needs identified in this assistive technology process. Indicate trial use, duration, and results. If no trial period was implemented, please explain. **Please do not use the student's name.**

	Device/Software Considered	*Trial Period*	*Duration of Trial*
1			
	Results/Explanation		
2			
	Results/Explanation		
3			
	Results/Explanation		
4			
	Results/Explanation		
5			
	Results/Explanation		
6			
	Results/Explanation		
7			
	Results/Explanation		
8			
	Results/Explanation		
9			
	Results/Explanation		
10			
	Results/Explanation		
11			
	Results/Explanation		
12			
	Results/Explanation		

III. Solution Selection

F. Selection

Describe how the recommended technology(ies) meet individual needs and will facilitate student outcomes. Is this a cost-effective solution to meet the individual student's needs? Describe why the team selected this technology over other options. Please do not use the student's name.

1. Technology Recommended
Rationale for Recommendations

2. Technology Recommended
Rationale for Recommendations

3. Technology Recommended
Rationale for Recommendations

4. Technology Recommended
Rationale for Recommendations

5. Technology Recommended
Rationale for Recommendations

6. Technology Recommended
Rationale for Recommendations

7. Technology Recommended
Rationale for Recommendations

8. Technology Recommended
Rationale for Recommendations

9. Technology Recommended
Rationale for Recommendations

10. Technology Recommended
Rationale for Recommendations

11. Technology Recommended
Rationale for Recommendations

12. Technology Recommended
Rationale for Recommendations

III. Solution Selection

G. Assistive Technology Requested

Please contact vendors to explore reduced pricing opportunities available in Ohio.

1 *Vendor* **Click to select a vendor** *Web*
Address *Ph* *Item*
, *Fax* *Model*
Contact *TF* **1** @ =
Shipping and Handling

2 *Vendor* *Web*
Address *Ph* *Item*
, *Fax* *Model*
Contact *TF* **1** @ =
Shipping and Handling

3 *Vendor* *Web*
Address *Ph* *Item*
, *Fax* *Model*
Contact *TF* **1** @ =

			Shipping and Handling
4	*Vendor*	*Web*	
	Address	*Ph*	*Item*
	,	*Fax*	*Model*
	Contact	*TF*	**1** @ =
			Shipping and Handling
5	*Vendor*	*Web*	
	Address	*Ph*	*Item*
	,	*Fax*	*Model*
	Contact	*TF*	**1** @ =
			Shipping and Handling
6	*Vendor*	*Web*	
	Address	*Ph*	*Item*
	,	*Fax*	*Model*
	Contact	*TF*	**1** @ =
			Shipping and Handling
7	*Vendor*	*Web*	
	Address	*Ph*	*Item*
	,	*Fax*	*Model*
	Contact	*TF*	**1** @ =
			Shipping and Handling
8	*Vendor*	*Web*	
	Address	*Ph*	*Item*
	,	*Fax*	*Model*
	Contact	*TF*	**1** @ =
			Shipping and Handling
9	*Vendor*	*Web*	
	Address	*Ph*	*Item*
	,	*Fax*	*Model*
	Contact	*TF*	**1** @ =
			Shipping and Handling
10	*Vendor*	*Web*	
	Address	*Ph*	*Item*
	,	*Fax*	*Model*
	Contact	*TF*	**1** @ =
			Shipping and Handling
11	*Vendor*	*Web*	
	Address	*Ph*	*Item*
	,	*Fax*	*Model*
	Contact	*TF*	**1** @ =
			Shipping and Handling
12	*Vendor*	*Web*	
	Address	*Ph*	*Item*
	,	*Fax*	*Model*
	Contact	*TF*	**1** @ =
			Shipping and Handling
			Total Amount Requested

IV. Implementation

H. Goal setting

Identify measurable goal(s) that you anticipate this individual student will achieve with the requested technology(ies) within one year. Goals should be stated in terms off measurable outcomes. The goals and objectives should be related to the student's current IEP or IFSP. **Please do not use the student's name**

I. Evaluation Plan

Indicate techniques and frequency for collecting data to evaluate student progress toward these goals. Please do not use the student's name.

J. Team Members and Responsibilities

Indicate the team members necessary to ensure implementation of the proposed assistive technology(ies) and their specific responsibilities. If application is approved, a list of signatures will be required. If parents or students are a part of the team, do not use their names; list the words "Parent" or "Student" only.

	Name/Title/Responsibilities
1	
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V. Local Share

K. Supports and Services

Describe specific supports and services which have been and/or will be provided by the district to support this student. Include alternate funding sources, training for staff, parents or students, teacher planning time, repair and maintenance or other technical assistance. List one support or service per page.

	Supports and Services	*Proposed/ Completed*	*Provider*	*Funding Source*	*Cost*
1					
2					
3					
4					
5					
6					
7					
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10					

Total Amount of Local Share

L. Other Funding Options.

List funding sources, other than ATIP, that have been considered or pursued for this student. This section is optional for applications that total $3,000 or less.

Funding Options	*Considered*	*Pursued*	*Results/Explanation*
Medicaid			
Personal Insurance			
MR/DD			
Rehab. Services Comm.: BVR. BSVI			
SchoolNet (i.e.: TLCF, Schoolnet Plus)			
ORCLISH (i.e.: Federal Quota, Impact Study)			
Civic or Community Organizations			
Ohio Dept of Health: BCMH			
Other			

VI. Significance

M. District Technology Plan Integration

Describe efforts to integrate assistive technology devices and services within the building and district, including incorporation in the district technology plan.

N. Access to the General Curriculum

How will the assistive technolog(ies) requested support instruction that allows the student to actively engage in the general education classroom and progress in the general curriculum? Please do not use student's name.