Assistive Technology Trial Use Plan

Date of Trial Period Planning: ______________________________

Individual Data

Name ___________________________
Phone ____________________________
Email ____________________________
Address __________________________

Case Coordinator(s) _______________________

Date of Birth _____________CA ____________
Disability ______________________________
ISP Date ________________________________
Medicaid ID# ____________________________
Medical Diagnosis ________________________
Social Security # ________________________
DHS # _________________________________
Day Program ____________________________
Vocational Case Manager _________________
Day ProgramAddress _____________________
____
Day Program Phone _____________________
Fax ______________________________

Team Members

<u>AT Extended Assessment Coordinator</u>
Name ______________________________
Title _______________________________
Phone ______________________________
Email ______________________________

Other Team Members
Name__________________Title ________
Phone ______________________________
Email ______________________________

Name__________________Title ________
Phone ______________________________
Email ______________________________

Name__________________Title ________
Phone ______________________________
Email ______________________________

Name__________________Title ________
Phone ______________________________
Email ______________________________

Overall Goal for Device Use

Goal for Use of the Device:

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How will we know if the trial is successful?

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What level of change is reasonable to expect during the trial period?

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____

How will we know if the trial is not working (What criteria will we use to stop)?

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____

Customary Environments Where Devices Will Be Used

1. Environment: ____
   Tasks: ____
   Person responsible for implementation: ______________________________
   Days to be used: ____
   Times to be used: ____

2. Environment:
   Tasks: ____
   Person responsible for implementation: ______________________________
   Days to be used: ____
   Times to be used: ____

3. Environment:
   Tasks: ____
   Person responsible for implementation: ______________________________
   Days to be used: ____
   Times to be used: ____

Specific Devices For Trial

Device #1 ____
Date of trial Initiation ____________________ Minimum length of trial period __________
Device trial review date ____
Source of Device for Trial ____
Contact person for technical assistance for trial ______________________________
Manufacturer:__________________ Manufacturer technical assistance number __________
Comments

Device #2 ____
Date of trial Initiation ____________________ Minimum length of trial period __________
Device trial review date ____
Source of Device for Trial ____
Contact person for technical assistance for trial ______________________________
Manufacturer:__________________ Manufacturer technical assistance number __________
Comments

Device #3 ____
Date of trial Initiation ____________________ Minimum length of trial period __________
Device trial review date ____
Source of Device for Trial ____
Contact person for technical assistance for trial ______________________________
Manufacturer:__________________ Manufacturer technical assistance number __________
Comments:

Trial Period Summary
(To be completed at the end of the assessment)

- ❑ How did the individual's performance change when using the devices?

- ❑ How did this person like using each device? Did the s/he prefer one of the devices?

- ❑ What are the advantages of using the devices?

- ❑ What are the disadvantages of using the devices?

- ❑ How long can the individual be expected to use the devices?

Team Recommendation: