

# CONNECTICUT **ASSISTIVE TECHNOLOGY** GUIDELINES



## **EXECUTIVE SUMMARY**

Connecticut State Department of Education

# Connecticut State Department of Education

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# **Connecticut Assistive Technology Guidelines**

Executive Summary

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## Rationale

**T**HE 2013 CONNECTICUT ASSISTIVE TECHNOLOGY (AT) GUIDELINES provides both school districts and Birth to Three service providers guidance to ensure that all children identified for AT services have access to AT through a framework for making decisions about the AT needs of children and students with disabilities. The guidelines outline procedures for making initial consideration decisions, assessment/evaluation, documentation, implementation, and evaluation of effectiveness of the delivery of AT devices and services. The guidelines support students and children served under the Individuals with Disabilities Education Act (IDEA) so they can access, participate and progress in the general curriculum; and address the functional capabilities of infants and toddlers.

This latest version is interactive with Web-based information and hyperlinked appendixes and periodic updates expected as the AT continuum continues to expand. The AT guidelines address differing stages of development, facilitate a review of processes, offer examples of best practices, explain the AT continuum, and clarify misconceptions to ensure that accommodations needed to meet goals are attainable. Through the guidelines and a collaborative effort across environments, parents, educators, therapists, administrators, and other professionals can best determine how to foster the participation in and utilization of AT services and devices that will deliver the greatest impact and increase confidence in abilities to identify goals and achieve positive outcomes.



## Executive summary

**T**HE 2013 CONNECTICUT ASSISTIVE TECHNOLOGY GUIDELINES is an online, interactive, Web-based document divided into two sections: section 1 addresses the needs for children and students ages 3–21 primarily in a school setting, and section 2 focuses on infants and toddlers in the Connecticut early intervention system and those providers. The guidelines are based on and embedded with the Quality Indicators of Assistive Technology (QIAT) with a focus on helping educators, parents, and advocates understand the rights of students with a disability regarding the use and availability of technology.

Assistive technology (AT) is a broad and inclusive term that covers everything from specialized drinking cups to wheelchairs and on a continuum from simple to low-technology (such as highlighters) through the most sophisticated and cutting-edge, high-tech tools (such as computers). The federal definition of an assistive technology device is “any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of children with disabilities” (Sec. 34 CFR §300.5). It should be noted that the IDEA improvement Act of 2004 added an exception for surgically implanted devices such as cochlear implants.

While the type of AT a child or student may use depends on the environment, the needs and abilities of the child, and the demands of the task, many types of AT are available to address needs in all areas of development:

cognitive, physical, communication, social/emotional, and/or adaptive.

To ensure that a child is able to access and benefit from needed AT device(s), the law places equal importance on the provisions of AT services. Under Section 34 CFR §300.6, an assistive technology service means any service that directly assists a child with a disability in the selection, acquisition, or use of an AT device. This includes:

- evaluating the needs of a child with a disability, including a functional evaluation of the child in the child's customary environment;
- purchasing, leasing or otherwise providing for the acquisition of AT devices by children with disabilities;
- selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing AT devices;
- coordinating and using other therapies, interventions, or services with AT devices, such as those associated with existing education and rehabilitation plans and programs;
- training or technical assistance for a child with a disability or, if appropriate, that child's family; and
- training or technical assistance for professionals (including individuals providing education or rehabilitation services), employers, or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of that child.

These guidelines describe the continuum of assistive technology from universally designed devices used by all through differentiated adaptations of low-tech/no-tech, moderate technology of simple electronics through high-tech of specialized individual adaptations or complex electronics. The guidelines review current federal and state laws ([section 1, appendix 4](#)) and policies regarding the Connecticut Birth to Three system ([Section 2—Guidelines for Infants and Toddlers](#)) as well as preschool and school-aged students ([Section 1—Guidelines for Ages 3–21](#)). Key topics include consideration of AT needs, assessment/evaluation, funding for AT, documentation, implementation and effectiveness, transition planning, administrative responsibilities, universal design for learning, formats for Accessible Instructional Material (AIM), the National Instructional Materials Accessibility Standard (NIMAS), and other resources.

## **Section 1: Guidelines for Ages 3–21**

The intent of Section 1 is to enable school districts to make informed decisions about AT considerations, implementation, and evaluation for their students, factoring in administrative support and professional development. It includes 13 chapters, a list of abbreviations and acronyms, frequently asked questions, resources for devices and services, several case studies, a glossary, and supportive documents and information in 12 appendixes.

AT supports and services are integral components in support of the Common Core State Standards. The standards recognize the significance of AT as supports and services for students with disabilities in meeting high academic standards to demonstrate their conceptual and procedural knowledge and skills in

mathematics and language arts.

To ensure that AT services and devices are provided according to mandates and standards, the QIAT ([section 1, appendix 1](#)) are embedded and used throughout the document to help districts and AT service-providers:

- improve AT services to increase educational access, participation and progress;
- improve the quality and increase the consistency of services; and
- support the implementation of IDEA and other legal mandates.

The QIAT were developed, revised and validated by professionals representing various perspectives and roles within the AT field due to concerns about the provisions of AT to students and to improve the educational achievement of students with disabilities by enabling districts to evaluate and develop AT services. The QIAT address eight areas of service delivery:

- consideration of the need for assistive technology during the individualized education program (IEP) meeting;
- evaluating the need for assistive technology;
- including assistive technology in the IEP;
- implementing the use of assistive technology;
- evaluating the effectiveness of assistive technology use;
- transitioning with assistive technology;
- administrative support for assistive technology services; and
- professional development and training in assistive technology (QIAT, 2005).

### **Consideration of AT**

The guidelines offer resources to address if a child has barriers or student has difficulty accessing the curriculum, participating in and progressing toward completing educational goals. When the student cannot accomplish the required tasks within the relevant instructional system or access areas with accommodations and/or modifications that are currently in place, then the consideration process for AT should be completed ([section 1, figure 1](#) and [appendix 5](#)).

The consideration process ([section 1, appendix 7](#)) includes a review of information about the skills and/or issues of access affecting performance, such as the environment(s) where the child or student completes the goals and activities, the task(s) that needs to be accomplished, and the present level of performance on that task. It reviews all accommodations and/or modifications and other strategies (technology or non-technology strategies) that are already in use. *If potential AT solutions or adaptation strategies are known, a trial use of the identified AT solution and documentation of the solution should occur.* If potential AT solutions are unknown to the planning and placement team (PPT)/IEP team, they may choose to consult with district personnel, recruit consultants who can assist the team in addressing AT, or refer the student for an AT evaluation/assessment with a documented action plan ([section 1, appendix 8](#) and [appendix 9](#)).

### **Assessment/Evaluation of AT**

Once the consideration process has determined that the student requires further assessment, an evaluation to determine the potential AT tools required to meet the identified student need may be necessary. The PPT/IEP team should not

complete an AT evaluation as a component of an initial evaluation to determine student eligibility for special education; rather, once the PPT/IEP team has determined a student's eligibility, it should consider AT and may recommend an AT evaluation when necessary.

A multidisciplinary team (including the student, parents and professionals) with the collective knowledge and skills needed to determine possible solutions that address the needs and abilities of the child should conduct assessments. The child's developmental performance in his or her customary environment such as the school, home and/or community is the basis for the assessment, and the focus is on what the child needs to do that he or she is not currently able to do, with reflection as to the success or failure of attempts already made within that environment.

### **Implementation of AT**

Once the PPT/IEP team has considered AT during the IEP process, the team should establish an implementation plan. AT implementation encompasses the ways that the IEP includes AT devices and services and integrates them into the student's educational program. The entire PPT/IEP team, including staff with AT expertise, helps support the student using AT. The PPT/IEP team's focus should be to ensure that the AT helps the student complete tasks necessary for progress toward IEP goals and objectives. A student's implementation plan should include statements of training necessary for the student, providers, and family as needed. The use of the AT in each environment and its implementation as part of an ongoing process based on the changing needs of the student and environment should determine training.

Since consideration and/or assessment data should be the initial basis for the AT implementation plan, the PPT/IEP team should monitor the plan and record data to determine student progress. The team's focus should be to ensure that the student is making progress. Implementation is effective when data show that student achievement and performance meet criteria (for an example of a data collection form, refer to [section 1, appendix 10](#) and [appendix 11](#)). The PPT/IEP team should base decisions about change on data review and analysis (TATN, 2009).

### **Effectiveness of AT**

The impact AT has on the user's quality of life, such as fostering participation, independence, and self-confidence, determines its effectiveness. To consider the impact and effectiveness of AT, it is important to examine the device in terms of its efficiency, usefulness, and availability for the student ([section 1, appendix 6](#)).

Regular evaluation of efficiency, usefulness, and availability enables service providers to consider the continuum of AT devices (from low-tech through high-tech) and cater to the needs of students with disabilities as well as meet changing academic and social demands ([section 1, appendix 9](#)). When AT is used across environments as it should be, the entire team is responsible for providing AT devices and services. The responsibility should not and does not remain only with the special educator or the AT specialist. A shared responsibility relates to all educators knowing what technology is being used; how the student is using it; when it should be made available; and responsibilities of the team members (i.e.,

programming, setting up, providing relevant information as necessary to program or set up the AT, backup plan, identifying responsibilities of the team members, and carrying them through).

### **Documentation**

The IEP should include AT documentation in multiple areas, such as in meeting minutes, special factors, present level of performances, recommendations, areas of strength when AT is already in place and helping a student to be successful, describing AT in goals and objectives, and/or any transition planning.

Clear documentation of AT devices and services is necessary in order that all PPT/IEP team members, including parents, fully understand how the AT devices and services will be provided. At the minimum, AT should be listed on the Accommodations and Modifications section on page 8 of the IEP and correspond with the services the PPT/IEP team recommends, which appear on page 11 of the IEP. The team should explain the AT devices and services as they relate to the student's active participation in educational activities, assessments, extracurricular activities, and typical routines.

### **Funding**

The guidelines address the layers of responsibility related to the district for AT services (in the selection, acquisition, or use of an AT device). If a child eligible for special education under IDEA requires AT to receive a free and appropriate public education (FAPE), the school district must provide the appropriate AT device(s) and services to ensure the child can access, participate in, and progress in the general education curriculum to the fullest extent possible. If the educational team recommends an AT evaluation, the school district is responsible for paying for the evaluation and is prohibited from excluding AT devices and/or services from a child's IEP based solely on expense. The district cannot require that a parent's health insurance pay for AT device(s) and/or services (although a parent may elect to do so).

If a parent requests an independent AT evaluation at public expense (because the parent does not agree with the school district's AT evaluation), the school district may either choose to fund an independent AT evaluation, or initiate a due process hearing to have a hearing officer decide whether the school district's AT evaluation is appropriate. The school district should choose one of these actions immediately. When the school district agrees to pay for the independent AT evaluation, the criteria under which the independent AT evaluation is obtained (including the location and the qualifications of the examiner) should be the same as the criteria that the school district would use when it does its own evaluation. When the school district initiates due process procedures and the hearing officer decides in favor of the school district, the parent may still obtain an independent AT evaluation but has to pay the costs associated with it.

The IDEA Improvement Act of 2004 allows a few exceptions for a school district's responsibility to pay for AT devices and/or services. As stated above, IDEA provides an exception to its definition of an AT device regarding medical devices that are surgically implanted or the replacement of such devices. If the device is part of the IEP or meets the requirements set forth under Section 504 ([section I, appendix 4](#)), the school district is responsible for providing the AT

device(s) and/or services. On “a limited basis and under unique circumstances” (Sec. 602[1][A]; 34 CFR §300.5) based on a child’s individual needs, devices such as hearing aids or eyeglasses *may* be considered AT devices. The consideration is the educational need of the device as opposed to the medical need, and the school district is responsible for providing the device or service if the PPT/IEP team determines that the child needs it to benefit from the educational program.

The party that pays for the majority of a child’s assistive technology device owns the device. If the school district fully funds the purchase of an AT device or equipment, the school district owns it; if the child’s private insurance or other third party purchases the device in whole or in part, then the device belongs to the child and only that child may use it.

Responsible, reasonable care for the AT device requires the PPT/IEP team to identify methods for periodic checks of the AT equipment, reporting problems, completing repairs, and how jointly responsible parties will address an acceptable substitute for the student’s device during these times. If the school district owns the AT device, it is responsible for ensuring proper safeguards and for replacement if the device is damaged or breaks. If a family purchases a device included in the IEP, the PPT/IEP team should decide who is responsible for repairing, replacing, and updating the device. If the school district or outside agency purchases the device, that agency is responsible for repairing, replacing, and updating it.

### **Professional Development**

Training others to understand and use technology tools is an essential part of the provision of AT services. Some training sessions are for large groups while others are for a single person or the members of a team for an individual who uses AT. Regardless of the size and purpose of the group, a professional development plan should clearly define outcomes that focus on determining student needs, the consideration process, funding AT, integrating technology into the curriculum, and training on AT devices and software.

Training in AT should occur frequently enough to address new and emerging technologies and practices, and be available on a repetitive and continuous schedule with ongoing opportunities tailored to the specific needs and skill levels addressed. It should follow research-based models for adult learning that include multiple formats and delivery at multiple skill levels of universal design.

Educational teams, including the possible development of an AT team, need clear leadership, direction, and support. Ideally, an AT team can comprise general and special educators, related service professionals, IT professionals, certified AT personnel, paraprofessionals, and administrators. The administrator’s responsibility is to keep the team focused, to understand the nature of change, to facilitate teams and their relationships, to help build knowledge, and to develop a clear message in terms of AT services and delivery (Fullan, 2001).

While AT service providers should evaluate the training’s effectiveness by measuring changes in practice that result in improved student performance, they should have competencies in a variety of areas. Best practices suggest that service providers have the following competencies:

- knowledge of the law and AT;
- knowledge of AT basics;
- AT assessment;

- AT implementation;
- collaboration and communication between team members; and
- resources and their appropriate use.

(Adopted from [California Department of Education](#) and [Florida Department of Education](#). For more information, refer to the [Wisconsin AT Initiative](#).)

### **Transition and AT**

AT is a significant aspect of planning for transitions throughout life, such as moving from one place or service to another, grade to grade, and school to postsecondary activities. When students with disabilities transition from one service to another, the AT they use in one setting should be provided in the next. To ensure this, when developing a statement of needed transition services consider include the following AT-specific information: a statement of the AT requirements in the receiving environment; information concerning equipment transfer, including user manuals and support documents; identification of key personnel involved in training, accessing funding options, and providing ongoing support; steps for using and maintaining the AT; an outline of team members' roles and training; follow-up activities, including assessment and evaluation; and an individualized implementation timeline (adapted from the QIAT Consortium's *Quality Indicators for Assistive Technology Services* and [fctd.info](#)).

AT elements are critical components to consider as a bridge to the next phases that the student may encounter to increase opportunities for success, while ensuring that transition needs are aligned with current and future skill sets. The law requires AT to be part of the postsecondary transition planning to include completing transition assessments, accomplishing functional tasks in community and employment settings, filling out applications, independent living skills, and accessing and participating in training and higher education settings. Even if a student has been using AT within the school setting, the tools that he or she will need upon graduation will not necessarily be the same. Therefore, determining specific needs based on the tasks and settings in which the student will work, train, learn, and/or live is important.

Identifying key agencies that may need to conduct further assessments or help purchase equipment that the individual has had success with or can train with is critical in ensuring that the supports remain seamless and address both generic and specific needs. This is especially important in cases where the student uses school-purchased devices that he or she will need to return upon graduation, unless the individual has arranged to buy the device from the school.

Teaching correct terms, safety skills around social networking (such as not to give out personal information unless you are confident of the person's role in their life), and access to legitimate support networks will increase the chances for a successful and healthy transition into the next phases of the individual's life. As knowledge grows with successful utilization of the AT, individuals become more confident in abilities and gain greater awareness of identifying and achieving personal goals.

### **Universal Design for Learning (UDL)**

Decisions about communal technology purchases should consider the needs

and abilities of all students. The Individuals with Disabilities Education Act explains universal design as “a concept or philosophy for designing and delivering products and services that are usable by people with the widest possible range of functional capabilities, which include products and services that are directly accessible (without requiring assistive technologies) and products and services that are interoperable with assistive technologies” (34 CFR § 300.44). When educators incorporate a UDL model, students with disabilities will likely have greater access to a wider range of tools and materials and their individual technology will be integrated into the school day.

### **Accessible Instructional Materials (AIM)**

For many students with a disability, a print-based learning environment can often create a barrier to accessing the general education curriculum. Often, students with print disabilities need alternatives to printed instructional materials. Assistive technology is often the delivery system through which the student receives these alternatives (or formats of Braille, Large Print, Audio, or Digital). Determining the proper format that a student receives is just as important as the device chosen for delivery—a two-part equation with the AT and AIM being equally effective to deliver access to the general curriculum. If only one part of the equation is offered, equal access is compromised.

Matching the student’s needs with the features required from the resources available is important. For that reason, in 2004 IDEA mandated creation of the National Instructional Materials Accessibility Center (NIMAC)/National Instructional Material Accessibility Standard (NIMAS) to provide instructional materials in a timely manner to blind students or other students with print-related disabilities. NIMAS covers instructional materials sold to elementary or secondary schools after July 19, 2006. Connecticut has developed a “hybrid process” to access AIM, which begins when a school district orders textbooks (refer to Purchase Order language and steps in guidelines). Students who qualify for copyright criteria because they are blind or have other print-related disabilities should be considered for AIM and if they have an IEP qualify to receive NIMAS-derived files. When a qualifying student is identified, a step-by-step explanation for acquiring specific material can be found in [section 1, appendix 12](#) and at the CSDE Web site ([NIMAC/NIMAS](#)) and/or Connecticut AIM Web site ([CTAIM](#)).

## **Section 2: Guidelines for Infants and Toddlers**

The guidelines for infants and toddlers emphasize the dynamics of the home with the family’s needs and priorities as central to the collaborative decision-making process and extent to which the child actually uses a particular device within family routines and activities. It includes 11 chapters, addresses myths and barriers, and delivers supportive documents and information in eight appendixes.

### **Consideration of AT**

Consideration of AT for an infant or toddler is not used in the place of other



needed services, rather the assistive technology:

- should increase, maintain, or improve the functional capabilities of a child;
- should enhance a child's participation in a routine or activity;
- should provide opportunities for learning;
- should complement existing services;
- should be developmentally and age appropriate;
- should be appropriate for the environment where the child spends his or her day; and
- may be needed by some children from all levels of the continuum, concurrently or consecutively.

The family's needs and priorities are central to the collaborative decision-making process and will determine the extent to which a child actually uses a particular device within family routines and activities.

### **Assessment of AT**

Because the needs of infants and toddlers changes rapidly (due to rapid growth and development, family expectations, family circumstances, where the child spends his or her day, and a change of caregivers), assessment of the infant and toddler is an ongoing process both in a formal and informal way. Although the type and extent of AT required may not be apparent when a child begins receiving Birth to Three services, the need for AT devices and services in other instances and developmental stages may be (or are often) unmistakable and immediate. Professionals of many disciplines (e.g., early intervention teachers, occupational therapists, physical therapists, speech and language pathologists, and audiologists) are the Birth to Three providers who typically consider the need and recommend AT for infants and toddlers.

Birth to Three providers should base assessments on the child's developmental performance in his or her customary environment, focusing on what the child needs to do or is not currently able to do within the routines of the family and those that are a priority for the family. AT devices ranging from no-tech to high-tech may be introduced at any point during the child's enrollment. Selection of low- and moderate-level devices may not require formal assessment, taking into account what AT the child has tried or currently uses with reflection on what is working and what is not.

The assessment process should provide the Individual Family and Support Plan (IFSP) team with clear recommendations about the purpose, selection, acquisition, and use of assistive technology ([section 2, figure 2](#)). Collaboration and communication with the child's primary medical provider regarding the selected AT is appropriate and necessary. The medical provider is an essential IFSP team member who participates in the procurement process when seeking funding from the child's health insurance carrier, including Medicaid. The child's health carrier often requires a detailed medical prescription of the devices to submit a claim for approval.

### **Documentation of AT**

Documentation of the need for AT devices and services is critical. In the IFSP development, the service coordinator can help set the stage for discussing family

priorities and needs by talking to or interviewing the family about the child's typical participation in everyday activities/routines. Section 4 of the IFSP (Daily Activities) enables the discussion to reveal what is working well during daily activities and what is not (examples of additional tools that may facilitate this process are the Routines-Based Interview (RBI) (Siskin Children's Institute, 2006) ([section 2, appendix 1](#) and [appendix 2](#)) and the Assessment of Family Activities and Routines (Thomas Jefferson University, n.d.) ([section 2, appendix 3](#) and [appendix 4](#)).

Once the IFSP team has determined that assistive technology is needed to support the child's outcome(s), the IFSP should reflect the assistive technology devices and services in as clear a fashion as possible. When assistive technology is required, the IFSP should include it, regardless of price, in several places and at a minimum in sections 6, 7 and 8.

### **Funding**

Once the child's Birth to Three program has determined the appropriate assistive technology device, it is responsible for putting funding options in place for obtaining AT. Currently the New England Assistive Technology Resource & Education Center (NEAT) is the gateway to vendors that assists Birth to Three programs with training, maintaining a database of devices, and obtaining AT devices.

The Birth to Three system funds assistive technology devices and services as the payer of last resort (being the responsibility of the family, program, and vendor to pursue all other funding options with a list for potential resources noted in the guidelines). If the device costs less than \$250, the program can pay for the device or can attempt to access third-party reimbursement. If the device costs \$250 or more, the program should pursue funding as well as submit the Assistive Technology Device Request Form Form 3-II ([section 2, appendix 5](#)) to the Birth to Three system. The service provider should submit this request form concurrent with the pursuit of third-party reimbursement.

Although there are specific protocols and procedures related to funding for the Birth to Three system (see [Funding Assistive Technology](#)), once AT has been identified the NEAT Center will help the provider find an appropriate vendor who will assist with insurance paperwork for both used and new equipment and through the family's health insurance (including Medicaid). The local Birth to Three program is responsible for initiating and participating in the process to bill commercial insurance or Medicaid for AT for those children whose parents have given permission. Insurance and Medicaid customarily fund equipment that fits under the category of durable medical equipment (DME). If commercial insurance pays for all or some of the cost of a device, that amount may be applied against the annual and lifetime caps for DME benefits in the child's health insurance plan.

If the program is working with a DME vendor, the vendor will likely take responsibility for the insurance billing. To access insurance (for a device costing any amount) or Medicaid funding (for devices over \$250), the program and vendor must provide with the insurance claim a physician's detailed prescription for the devices (the vendor will often assist by providing the specific device and accessories to the primary medical provider).

The Birth to Three provider prepares a Letter of Medical Necessity (LMN) ([section 2, appendix 6](#)). The customary items within the LMN should include:

- personal benefit (how does this device increase participation in daily activities related to independence, choice, self-determination, reduced costs for caregivers, and living a full, abundant, and dignified life);
- investment (besides the health and functional benefits of the device, what are the costs of *not* providing the requested AT); and
- equipment choice (why is this particular equipment the most appropriate choice, what features make this equipment the right choice, and can it adapt to the child's needs over time even though it may cost more initially) (Goebel, 2009).

The Birth to Three system is responsible for funding only equipment intended to achieve functional outcomes identified on the IFSP; however, no new devices or equipment should be requested for children who are 2 years, 9 months of age or older, as equipment requested during this period would not be available long enough to make progress on identified outcomes (except for initial hearing aids if the child is newly enrolled in Birth to Three after age 2 years, 9 months).

The Birth to Three program is advised to submit the Assistive Technology Device Request Form ([section 2, appendix 5](#)) to the Birth to Three system *while* pursuing third-party funding. A copy of the current IFSP must accompany this form. Requests should reflect all costs for the acquisition of equipment, including shipping and handling, fitting and customization, and extended warranties. The Birth to Three system has an approved dispensing fee for services needed to acquire hearing technology for young children, and Medicaid has its own rate for dispensing fees.

The Birth to Three central office staff will review the AT-funding request and return a decision to the provider program on Form 3-II ([section 2, appendix 5](#)). If approved, Form 3-II will include the date of approval and the maximum amount of reimbursement allowed. Despite specifics related to insurance, unique circumstances, and schedules (see [Accessing Birth to Three Funding](#)), the requesting program should notify the Birth to Three fiscal office so that it does not set aside funds unnecessarily if funding has been requested and approved by the Birth to Three system and a third-party covers the full cost of the device.

The party that paid for a majority of a device owns assistive technology devices purchased for children enrolled in the Birth to Three system. If third-party funding ends up paying more than 50 percent of the purchase price of the device, then the device belongs to the family. If Birth to Three funds pay for 50 percent or more of the device, the Birth to Three system owns that device. Programs are responsible for tagging all equipment purchased with Birth to Three funds with inventory tags (supplied by the Birth to Three fiscal office) to record information in the database that NEAT maintains.

Whenever possible, the local Birth to Three programs should consider obtaining insurance and/or maintenance contracts when purchasing AT. Parents are also requested to insure the AT devices under their homeowner's or renter's insurance policy if possible.

The child's Birth to Three program is responsible for maintaining and repairing the AT device. If any devices or services are part of a child's IFSP, then the technology must be available to the child for fulfilling the IFSP's outcomes

and objectives. If a device needs repair or maintenance, the Birth to Three program is responsible for providing alternative access or temporary use of another device or equivalent during the time the regularly used device is out of service. The NEAT Center provides minor repair service for AT that the Birth to Three system owns. *Note:* If the child continues to use assistive technology after age 3, the Birth to Three system will not assume responsibility for any repair or maintenance.

### **Implementation of AT**

The implementation of assistive technology involves the child's entire team working together and sharing responsibility to support the child's use of the assistive technology according to a collaboratively developed written plan. Parent or caregiver input regarding preferences and feelings about devices is often a determining factor for successful implementation and use of AT (Illinois: Early Intervention Assistive Technology Guidelines, 2007).

The implementation plan should be easy to understand and delineate the steps of a routine/activity (identified by the family) when AT will be used, the devices that will be used, what the adult will do, and what the child is expected to do as a result of using the AT (examples of an implementation plan can be found in [section 2](#), [appendix 7](#) and [appendix 8](#)).

All members of the IFSP team must understand what is expected of them concerning the implementation of the AT, such as:

- why the AT was selected;
- the purpose the AT serves;
- how it enhances the child's functional skills;
- when and how often it will be used;
- how AT will be used in combination with other AT;
- which adults are responsible to ensure that the AT is used as planned; and
- how the AT will be coordinated with other therapies.

As the implementation plan is carried out, the service provider should monitor the child's performance and adjustments made to support the child's progress. Following acquisition of the devices, the Birth to Three provider is responsible for:

- setup;
- organization of equipment and materials;
- temporary use of a comparable device if the original is unavailable for an extended time; and
- timely replacement of a nonrepairable device.

The Birth to Three professional responsible for the AT services coordinates collection of this information and interpretation of changes. The adults who will assume responsibility to record information about the child responses to the AT should be clearly determined so that assessment of AT effectiveness occurs informally during routine early intervention visits as well as formally at IFSP reviews. There may be a recommendation to the IFSP team, at a review, to engage the consultation of a specialist or to schedule a formal assistive technology assessment, if the team has not completed one previously.

Some assistive technology categories require the inclusion of designated licensed professionals for the assessment, implementation, and evaluation process.

The Birth to Three program is responsible for locating and engaging providers who possess the needed expertise when the program lacks the competency to select a needed AT device.

Evaluation of AT effectiveness is a dynamic, responsive, ongoing process and occurs over time. Throughout the child's enrollment in Birth to Three, examination of what is/is not working and why, along with which elements need to be changed should occur, including measuring changes in the child's performance related to functional outcomes.

### **Transition and AT**

All children enrolled in the Birth to Three system are required to have a plan in place to ensure a smooth transition to preschool or other appropriate services and supports. The IFSP team must develop a transition plan as part of an IFSP meeting (initial, periodic review, or evaluation of the IFSP held at least annually), which it can update several times to reflect the different stages of the transition planning process. Section 5 of the IFSP should record transition steps and services. Transition plans that include assistive technology should clearly address the use of assistive technology and the anticipated need for continued use once the child is no longer enrolled in the Birth to Three system.

Transition plans for children who use assistive technology should address the child's use of AT devices and services as the children transfer from one setting to another. The transition plan should list any AT obtained through the Birth to Three system and how the child will use it once he or she transitions out of the Birth to Three system.

When a child exits the Birth to Three system, assistive technology equipment Birth to Three owns and that the child uses may transition with him or her so that the child can continue to use the device at home, in school, or in the community as needed and as appropriate. However, the Birth to Three system will no longer assume responsibility for repair or maintenance.

### **Training and AT**

Training for the child, family, and team are integral to implementation and may be ongoing as needs change, participating adults change, and the child's abilities change. Early intervention professionals are responsible for providing appropriate instruction and follow-up for all adults involved in using the AT.

The Birth to Three system has a contract with the NEAT Center in Connecticut to provide training to Birth to Three programs and has purchased seating at each workshop, which it offers without cost to Birth to Three providers. The center schedules training events each year specific to early interventionists as well as assistance in selecting appropriate and cost-effective devices.

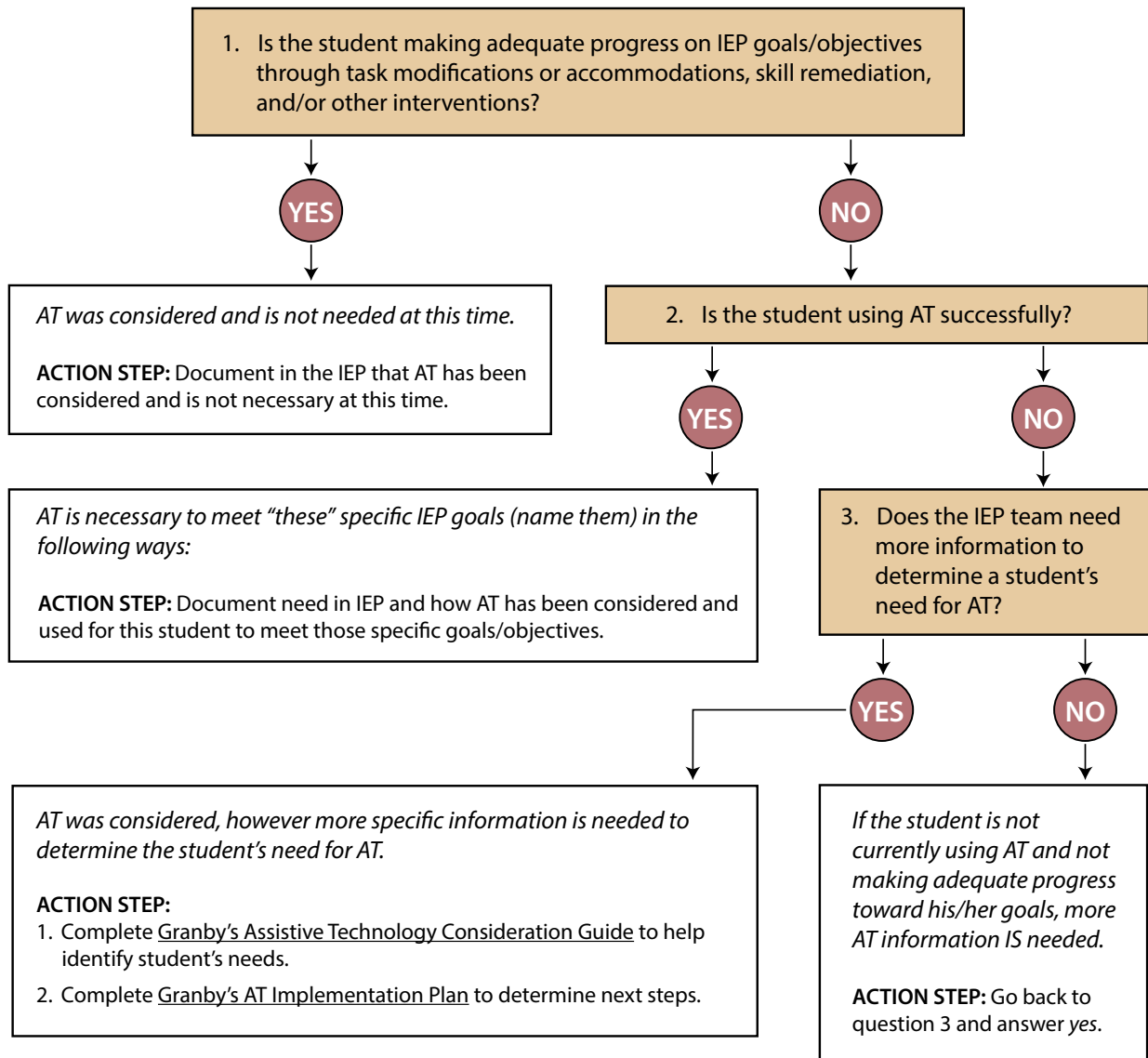
## Conclusion

**T**HIS REVISION OF the Connecticut Assistive Technology Guidelines (2013) helps define the process for considering, implementing, and evaluating technologies that equalize the learning experience for infants and toddlers (in Birth to Three) as well as preschool and school-aged children.

Technology influences every aspect of our lives and plays a vital role in education; it is part of the curriculum, a means of delivering instruction, as well as a tool to enhance the learning process. Technology has transformed education, making it interactive, while opening new avenues for children and students with disabilities making it possible to experience positive outcomes and achieve goals.

Figure 1. Consideration of AT within the IEP Process Flow Chart

## Considerations of Assistive Technology (AT) within the IEP Process

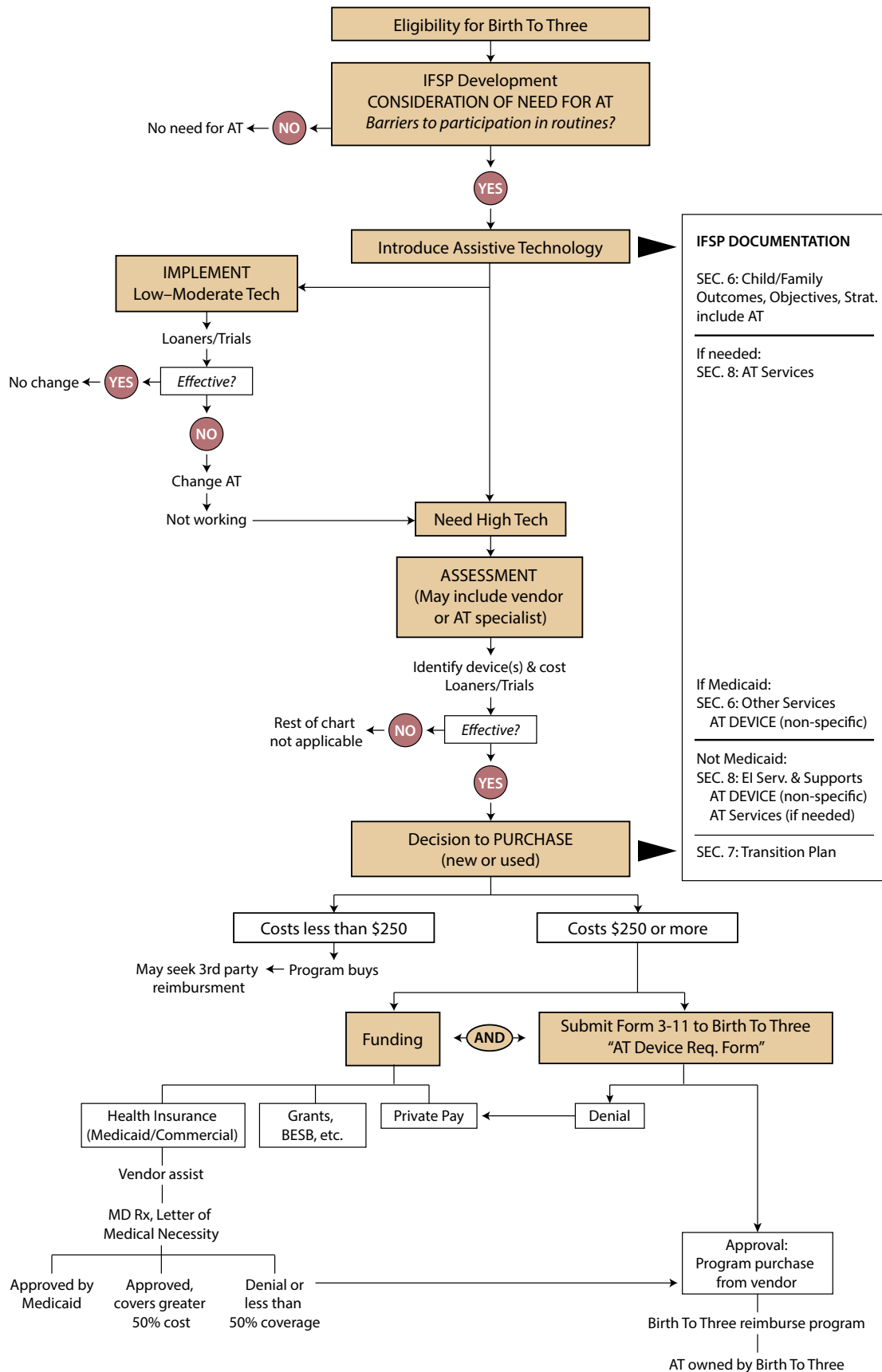


Adapted from:

Zabala, J.S. (1994). The SETT framework: Critical questions to ask when making informed decisions about AT (online). Available at <http://www.joyzabala.com/Documents.html>.

Bowser, G. & Reed, P. (1988) Education tech points: A framework for AT planning: Roseburg, OR: Oregon Assistive Technology project.

Figure 2. Assessment Process





## Section 1 appendixes

[Appendix 1 – QIAT Indicators](#)

[Appendix 2 – QIAT self-evaluation Matrices](#)

[Appendix 3 - QIAT self-evaluation score sheet](#)

[Appendix 4 – Laws and Policies](#)

[Appendix 5 – AT consideration cycle](#)

[Appendix 6 – AT cycle toolkit](#)

[Appendix 7 – AT consideration checklist](#)

[Appendix 8 – WATI assessment form](#)

[Appendix 9 – AT consideration resource](#)

[Appendix 10 – AT implementation data collection form](#)

[Appendix 11 – Sample AT implementation data collection form](#)

[Appendix 12 – Audiobook Formats](#)

## Section 2 appendixes

[Appendix 1: Routine Based Interview Outline](#)

[Appendix 2: Routines Based Interview Form](#)

[Appendix 3: Assessment of Family Activities and Routines](#)

[Appendix 4: Assessment of Family Activities and Routines \(Sample\)](#)

[Appendix 5: Assistive Technology Device Request Form, CT Birth to Three Form 3-11](#)

[Appendix 6: Letter of Medical Necessity \(Sample\)](#)

[Appendix 7: Child Caregiver Interaction Plan](#)

[Appendix 8: Child Caregiver Interaction Plan \(Sample\)](#)

## Suggested readings

Sections 1 and 2 of the assistive technology guidelines each contain a complete list of references for further reading.

Fullan, M. 2001. *The new meaning of educational change* (3rd ed.). New York: Teachers College Press.

Goebel, G. 2009. *Funding Adaptive Mobility Equipment for Young Children with Disabilities*. Retrieved October 31, 2012 from [http://www.rifton.com/practiceareas/Earlyintervention/Rifton\\_FundingSources.pdf](http://www.rifton.com/practiceareas/Earlyintervention/Rifton_FundingSources.pdf).

Goodman, S. 1991. *Assistive Technology and the IEP*. Washington DC: Assistive Technology Funding and Systems Change Project.

Illinois State Board of Education: Early Childhood Education. 2007. *Early Intervention Assistive Technology Guidelines*. Illinois State Board of Education.

Quality Indicators for Assistive Technology: Guiding the provisions for AT services. Retrieved October 24, 2012 from [http://natri.uky.edu/assoc\\_projects/qiat/documents.html](http://natri.uky.edu/assoc_projects/qiat/documents.html).

Wisconsin Assistive Technology Initiative. n.d. *Implementing trails with assistive technology*. Retrieved March 29, 2012, from <http://www.wati.org/content/supports/free/pdf/form/TrialUse-Form.pdf>.

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