

GENERAL INFORMATION	
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STUDENT NAME	SCHOOL
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1. What task is it that we want this student to do, that s/he is unable to do at a level that reflects his/her skills/abilities (writing, reading, communicating, seeing, hearing)? Document by checking each relevant task below. Leave blank any tasks that are not relevant to the student's IEP.
2. Is the student currently able to complete tasks with special strategies or accommodations? If yes, describe in Column A for each checked tasks.
3. Is there available assistive technology (either devices, tools, hardware, or software) that could be used to address this task? If none are known, review WATI's AT Checklist. If any assistive technology tools are currently being used (or were tried in the past), describe in Column B.
4. Would the use of assistive technology help the student perform this skill more easily or efficiently, in the least restrictive environment, or perform successfully with less personal assistance? If yes, complete column C.

ASSISTIVE TECHNOLOGY CONSIDERATION			
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	A IF STUDENT CURRENTLY COMPLETES TASK WITH SPECIAL STRATEGIES/ ACCOMMODATIONS, DESCRIBE.	B IF STUDENT CURRENTLY COMPLETES TASK WITH ASSISTIVE TECHNOLOGY TOOLS, DESCRIBE.	C DESCRIBE ANY NEW OR ADDITIONAL ASSISTIVE TECHNOLOGY TO BE TRIED
TASK			
<input type="checkbox"/> Motor Aspects of Writing			
<input type="checkbox"/> Computer Access			
<input type="checkbox"/> Composing Written Material			
<input type="checkbox"/> Communication			
<input type="checkbox"/> Reading			
<input type="checkbox"/> Learning/ Studying			

ASSISTIVE TECHNOLOGY CONSIDERATION

TASK	A IF STUDENT CURRENTLY COMPLETES TASK WITH SPECIAL STRATEGIES/ ACCOMMODATIONS, DESCRIBE.	B IF STUDENT CURRENTLY COMPLETES TASK WITH ASSISTIVE TECHNOLOGY TOOLS, DESCRIBE.	C DESCRIBE ANY NEW OR ADDITIONAL ASSISTIVE TECHNOLOGY TO BE TRIED
<input type="checkbox"/> Math			
<input type="checkbox"/> Recreation and Leisure			
<input type="checkbox"/> Activities of Daily Living (ADLs)			
<input type="checkbox"/> Mobility			
<input type="checkbox"/> Environmental Control			
<input type="checkbox"/> Positioning and Seating			
<input type="checkbox"/> Vision			
<input type="checkbox"/> Hearing			

5. Are there assistive technology services (more specific evaluation of need for assistive technology, adapting or modifying the assistive technology, technical assistance on its operation and use, or training of student, staff, or family) that this student needs? If yes, describe what will be provided, the initiation and duration.

PERSONS PRESENT

DATE