**Consideration for Assistive Technology Checklist**

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Check an area in which there is concern about the student functioning as independently as possible.**

**\_\_\_\_** Academic

 \_\_\_\_ reading \_\_\_\_writing \_\_\_\_math \_\_\_\_learning/studying

\_\_\_\_Communication

 \_\_\_\_understanding language \_\_\_\_using language \_\_\_\_speaking clearly

\_\_\_\_ Access

 \_\_\_\_computer access \_\_\_\_mobility \_\_\_\_seating & positioning \_\_\_\_environmental control

\_\_\_\_ Activities of Daily Living

 \_\_\_\_play \_\_\_\_recreation/leisure \_\_\_\_self-care \_\_\_\_staying on-task

\_\_\_\_ Vision

\_\_\_\_ Hearing

\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ There are no Assistive Technology Concerns at this time.

**If there is no concern, check “no” in the Special Considerations section of the IEP.**

**If there is a concern in any area above, please mark “yes” in the Special Considerations Section of the IEP.**

What **task** in the area identified above does the team want this student to perform that she/she is unable to because of his/her disability?

Are there any **new** or **additional** assistive technology services to be tried to address these barriers? If yes, describe. (*Document in Services section of IEP as well.)*

Is there a need for further investigation and/or assessment to determine assistive technology needs? (*Describe plan and document in Services section of IEP as well.)*