

Screening Tools for Assistive Technology

This material is provided by the North Dakota Interagency Program for Assistive Technology (IPAT) which supports people with disabilities, including those experiencing the effects of aging, who require assistive technology devices and/or services.

These tools are from a section of a comprehensive guide for assistive technology planning, "Technology for all: A guide to solving the puzzle," developed by the IPAT project. The complete guide is available by calling 1-800-265-IPAT (4728) V/TT.

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Summer, 1998

SCREENING FOR ASSISTIVE TECHNOLOGY

Systematic procedures for identification, evaluation, and individual program planning for assistive technology needs of individuals will assure equitable access to assistive technology solutions. The development and adoption of protocols for addressing assistive technology which have been systematized assure best practices and equal access for all persons throughout the continuum of the system's responsibility.

An *assistive technology (AT) screening tool* provides a systematic method to screen for potential assistive technology solutions for a variety of needs. Screening each individual eliminates the potential for presumptive denial of the need for assistive technology. The following are examples of assistive technology (AT) screen tools. The ***AT Trigger: Screening Document for Potential Assistive Technology Needs***, developed in North Dakota for use in schools, and the ***Screening for AT Within VR***, developed by Florida Vocational Rehabilitation.

AT Trigger: Screening Document for Potential Assistive Technology Needs

Completion of the following questionnaire will assist in identifying the student's potential need for a consultation regarding assistive technology accommodations and/or evaluation.

Student's Name _____

Date of Referral _____ Age _____

Grade Level _____ Teacher _____

Physical Characteristics Does the student have physical characteristics which significantly set him/her apart from same age peers (i.e., posture/habits)? yes no

Mobility/Gross Motor Does the student need special assistance to get to and from places? yes no

Fine Motor Skills Does the student have difficulty performing basic age appropriate tasks which require the use of hands? yes no

Hearing, Speech, Vision Does the student have difficulty hearing, speaking, or seeing? yes no

Academic Does the student experience academic difficulties? yes no

**Recreation
and Leisure**

Does the student have difficulty participating in playground activities, sports, or other pastimes?

yes no

**Jobs and
Vocations**

Does the student avoid or have difficulty securing part-time job opportunities?

yes no

**General
Health**

Does the student need assistance with academic tasks due to problems related to alertness, vitality, stamina, strength, endurance, or independent work skills?

yes no

Self Help

Does the student need help from anyone in regard to self help skills, such as eating, dressing, personal hygiene and grooming, or using the restroom?

yes no

PLEASE COMPLETE THE FOLLOWING SIMILARLY TITLED FOLLOW-UP SECTION(S)
FOR EACH YES RESPONSE FROM PREVIOUS PAGE.

AT Trigger: Screening Document for Potential AT Needs

Physical Characteristics		Yes	No	N/A
1.	Can the student sit upright while completing tasks at his desk (i.e., not slouched, resting head on desk or hand, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Can the student participate in and complete classwork regardless of habits (i.e., thumbsucking, chewing on pencils, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Can the student maintain an appropriate posture while seating and actively engaged in a motor task (i.e., keyboarding, cutting)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Can the student participate in playing and running activities without atypical body postures?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Can the student sit on floor without assuming asymmetrical postures?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Can the student walk independently within the school setting at a rate consistent with that of peers?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments: _____

Mobility/Gross Motor		Yes	No	N/A
1.	Does the student have the motor skills necessary to get to/from school and/or get around within the school?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Can the student participate in physical activities (structured or independent) and navigate within the classroom without tripping or stumbling?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Does the student climb and descent stairs independently?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Is the student able to open heavy doors independently?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Is the student aware of directionality (i.e., right or left, following the flow of traffic)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Is the student able to maintain balance while performing an activity (i.e., putting on boots, getting up from floor)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Can the student carry objects while walking independently?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments: _____

Fine Motor Skills

	Yes	No	N/A
1. Can the student cut and/or handle scissors independently?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Can the student use writing utensils (i.e., markers, paint brush, pencil, crayons) independently?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Can the student complete written tasks independently?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Can the student copy materials from a book?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Can the student copy materials from a board?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Can the student tie shoes, button, snap, and/or use zippers independently?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Can the student open doors, turn door knobs or handles, water faucets, pages in a book, and use manipulatives?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Can the student keyboard?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Can the student draw, form letters, stay on the line, and/or trace?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments: _____

Hearing, Speech, Vision

1. Does the student speak to communicate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Are others in the school environment able to understand the student's speech?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Does the student respond appropriately to speech and noises in the environment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Is the student able to see printed materials presented in the classroom?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Is the student able to see toys/objects in the classroom environment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Is the student able to transfer information from a book, chart, and/or chalkboard to paper?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments: _____

Academic

1. Does the student understand basic cause/effect?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the student exhibit choice making skills?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Does the student have the attention span needed to handle school/daily living tasks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Does the student have the sequencing skills necessary to accomplish school/daily living tasks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Does the student have the memory and problem solving skills necessary to accomplish school/daily living tasks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

		Yes	No	N/A
6.	Can the student visually track along a line of print?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Can the student read texts independently?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	Can the student write legibly at a reasonable rate in a reasonable time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	Can the student write legibly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	Can the student accomplish written tasks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.	Can the student spell enough of the words needed to communicate in written form?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.	Can the student perform math tasks needed for school or for daily living?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.	Can the student take notes at the level needed in school and/or in daily living?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments: _____

Recreation and Leisure

1.	Is the student able to use the playground equipment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Is the student able to participate in group recreational activities, such as sports and group games?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Is the student able to take part in activities requiring fine motor skills, such as board games, art, etc.?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Is the student able to participate in extra-curricular activities, such as clubs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments: _____

Jobs and Vocations

1.	Can the student access/participate in vocational or job activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Is the student able to maintain a position for extended periods of time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Can the student use a computer without modifications?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Can the student hold the phone and dial independently?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Is the student able to access everything at a job site (i.e., desk, bathroom, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments: _____

General Health

	Yes	No	N/A
1. Does the student breathe without difficulty?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the student demonstrate sufficient stamina to maintain academic involvement throughout the school day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Is the student able to utilize doors, stairs, lockers, etc. within the school environment independently?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Is the student able to maintain focus and engagement with the academic material presented?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Does the student demonstrate physical strength needed to participate in school activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Is the student's health condition adequate for satisfactory school performance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments: _____

Self Help

1. Can the student independently use various clothing fasteners?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Can the student organize and maintain his/her school supplies and materials?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Is the student able to participate in school lunch independently?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Can the student maintain personal hygiene necessary for social acceptance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Is the student able to use restrooms independently?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments: _____

If the answer to any of these questions is NO, then a consultation by the Assistive Technology Team should be requested.

Screening for Assistive Technology Within Vocational Rehabilitation

Please answer the following questions by checking the appropriate box. Your answers will assist your counselor in providing services you may require to successfully complete your rehabilitation. If the answer to any of these questions is YES, then proceed to the companion section of the Assistive Technology Pre-Assessment Form.

	Yes	No
Do you need assistance to get to and from places, such as work, school, or the grocery store? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you use a cane, walker, wheelchair, or other aid in walking? _____	<input type="checkbox"/>	<input type="checkbox"/>
Has learning new information ever been difficult for you? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any difficulty hearing, speaking, or seeing? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you need assistance to write? _____	<input type="checkbox"/>	<input type="checkbox"/>
To perform your work do you use devices other than the tools provided by your employer? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you need help from anyone with your daily living skills, such as dressing, preparing meals, or bathing? _____	<input type="checkbox"/>	<input type="checkbox"/>

Assistive Technology Pre-Assessment Form

Counselor: The questions below are recommended as follow up to YES answers offered by your client in the Application's general questions regarding their use or need of rehabilitation technology. The questions below are worded for general context only and should be amplified, clarified or re-worded as per your client's level of understanding. Note: If the answer to any of these questions is NO then a rehabilitation engineering and AT assessment may be appropriate. If the answer to any of these questions is N/A then a call to the Rehabilitation Engineering Technology Team for clarification is appropriate

		Yes	No	N/A
T	Transportation			
1.	Do you have access to transportation? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	If you use a mobility device, can you transfer to a car seat? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Do you have a driver's license? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Have you completed a driver's education course? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Can you drive a vehicle from the existing seat? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Can you ride a city bus? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments: _____				

- | A | Ambulation | Yes | No | N/A |
|----------|---|--------------------------|--------------------------|--------------------------|
| 1. | Can you walk by yourself? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. | Can you walk up a hill or flight of stairs by yourself? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. | Can you stand up by yourself? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. | Can you stand for 30 minutes? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. | Can you lift a telephone book? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. | Can you lift a bag of potatoes? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | Are you able to reach above your head? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Comments: _____

- | L | Learning | Yes | No | N/A |
|----------|--|--------------------------|--------------------------|--------------------------|
| 1. | Can you learn by watching? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. | Can you learn by listening? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. | Can you learn by doing? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. | Can you write down your thoughts? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. | Can you remember things well? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. | Can you read printed or had-written messages or notes? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | Can you follow verbal directions? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | Can you follow written directions? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | Can you write with a pen or pencil? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | Can you spell most words? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. | Can you keep your own check book? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Comments: _____

- | HSV | Hearing/Speech and Vision | Yes | No | N/A |
|------------|---|--------------------------|--------------------------|--------------------------|
| 1. | Can you understand voices most of the time? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. | Can you use the telephone? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. | Can you hear clearly when you use the telephone? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. | Do you speak to communicate? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. | Do people understand you when you speak to them? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. | Do you read the paper, books, or your mail? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | Can you distinguish sounds, i.e., horns, bells, sirens? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Comments: _____

- | W | Writing | Yes | No | N/A |
|----------|---|--------------------------|--------------------------|--------------------------|
| 1. | Do you need any special help to hold a pen or pencil? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. | Do you write notes, messages, reports? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Comments: _____

J	Job Site	Yes	No	N/A
1.	Can you sit for longer than 30 minutes without pain? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Can you use a computer without help? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Can you hold the phone and dial by yourself? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Is the chair that you sit in comfortable for you? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Do your feet touch the floor when you sit at your workstation? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Can you type or work for 30 minutes without pain in your hands, arms, shoulders, neck, or back? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Can you use the restroom facilities at your school or work? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments: _____

PC	Personal Care	Yes	No	N/A
1.	Can you get up and dress without help? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Can you shop and prepare your own meals? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Can you do your own laundry without help? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Can you bathe or shower without assistance? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	In an emergency can you get out of your home by yourself? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	In an emergency can you dial 911 and give directions to rescue persons to get to your house and help you? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Can you get in and out of your home by yourself? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments: _____

An **assistive technology assessment process** provides a comprehensive approach to determine individual needs. General accepted components of an assistive technology assessment process include:

- a) *Identification of an individual's functional needs*, i.e. communication, education/vocational, mobility/seating and positioning, recreation/leisure, and environmental control.
- b) *Gathering background information on individual's functional abilities*, i.e. disability type, prognosis, motor, cognition, communication, sensory, education, and vocational, individual's personal characteristics (assistive technology experience, interests, motivation, attitude, desire for independence, environment).
- c) *Matching the individual and assistive technology* by insuring that the technology solution is individualized, fits individual's functional abilities, personal characteristics and environmental, and remains as simple as possible.
- d) *Investigating device options*, i.e., ease of use, reliability, cost.
- e) *Providing experiences in trial use* with selected assistive technology devices.
- f) *Re-examining options*, if necessary.
- g) *Developing training plans* to support the individual, family members, and support personnel in device use and implementation.

- h) *Identification of funding sources* to provide for equipment trial use and for purchasing of devices.
- i) *Identifying follow-up activities* to ensure an on-going process for systematic examination of device use and implementation necessary to meet the individual's evolving needs.

Individual programming for assistive technology needs to fit within the decision making sequence that meets the legal requirements under whichever program the individual is served.

Under the Rehabilitation Act Amendments of 1992 (Public Law 102-569), state rehabilitation agencies must look at all options, including assistive technology interventions. Therefore, vocational rehabilitation agency's plans should identify how assistive technology is addressed within the Individualized Written Rehabilitation Plan (IWRP).

Children with disabilities who need assistive technology devices and services in order to benefit from education are entitled to have access to such devices and services under three laws: the Individuals with Disabilities Education Act (IDEA), Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act of 1990. Therefore, school systems should identify how assistive technology is addressed within the Individualized Educational Plan (IEP) or the 504 Plan.

Directory of North Dakota Assistive Technology Resources

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701-265-4807
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1-800-265-IPAT (4728)
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701-265-3150 Fax
1-800-265-IPAT (4728) V/TT
duncan@pioneer.state.nd.us

Peggy S. Shireley, SW Coordinator
4007 State St. #101, Bismarck, ND 58501
701-328-9544 V
701-328-9545 Fax
shireley@btigate.com

Dud Zimmerman, NW Coordinator
400-22nd Ave. NW, Minot, ND 58703
701-857-8630 V
701-857-8555 Fax
dud@minot.com

Connie Rawls, Project Support
1-800-265-IPAT (4728) V/TT
rawls@pioneer.state.nd.us

AT Info-Line
1-888-214-2780 V/TT
Get answers to all types of AT questions
List and look for used AT equipment

IPAT Equipment Loan Library
1-800-421-1181
Call to borrow AT equipment/devices for trial use

Adaptive Equipment Services

1-800-252-4911 ext. 4583

Inquire about equipment fabrication or equipment vendors

Protection & Advocacy

1-800-472-2670

Get help in resolving AT service/device barriers



1-800-265-IPAT (4728) V/TT
<<http://www.ndipat.org>>