

Assistive Technology Outcomes Checklist

Use this form to:

- *Determine effectiveness of AT Tools trialed in AT Trial Plan*
 - *Make AT Recommendations*

Student:	Date:
Date Trial was Initiated:	School:
Case Manager:	AT Consultant:
Reason for Consultation:	

OUTCOME

Goal	Criteria	Have criteria been met?
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No

Tools/Devices	Does the student demonstrate operational competence to access educational materials?		What is the student's level of competence using the features below? N/A = not applicable 1 = Needs Prompting 2 = Independent			Accommodations recommended?		
	YES	NO	N/A	1	2	YES	NO	Further trials needed

RECOMMENDATIONS

Device/Software/Features	Purpose (When to Use the Tool)	Assistive Technology Services

*If adding Assistive Technology Consultation to the IEP, please indicate this under *Supports for School Personnel on Behalf of the Student*.

*For students receiving AT supports for communication, please indicate the following under *Student Needs Relating to Special Factors*:

- Does the student need an assistive technology device and/or service? - "Yes"
- If yes, does the Committee recommend that the device(s) be used in the student's home? - "Yes"

Wayne-Finger Lakes BOCES

Revised: 5/15/19

**SETT: Student, Environment,
Task, Tools**