8665 Gibbs Dr. #100 San Diego, CA 92123 * 858-278-5420 x121 * fschlosser@ucpsd.org

Background Information Packet

INSTRUCTIONS: Answer all questions as best you can. Mark N/A to all questions that are not applicable to you. If you have any questions or concerns, please contact the SDATC.

I. Client Information

Name: ____ Date of birth: ____________________

Contact Name: ____

E-mail Address: ____

Telephone: (home)__________________________________ (cell) _______________________

Address: ____

____

____

Living Arrangements:
(Circle most appropriate) with family / with caregiver / independently / group home

Person completing this form:

____
Name Relationship to consumer

SDRC Service Coordinator: ____

Phone Number:_______________________________ Consumer UCI #:___________________

School/Day Program/Work:____

Contact Participant: ___________________________ Phone Number:____________________

CCS Unit Contact: _____________________________ Phone Number:____________________

Health Insurance Plan: (circle) PPO POS HMO COBRA Other: ____________________

Insurance Company: ______________________ (example: HealthNet, Tricare/TriWest, Kaiser*)

Policy Number: _________________________ Group: _______________________________

You will need to provide a copy of insurance cards front and back

**** IMPORTANT **** If you have **Kaiser Permanente** as your primary insurance, **STOP HERE**!!!

Kaiser DOES NOT accept UCP Assessments. Contact your General Practitioner and request a referral to the Kaiser Speech Therapy Department.

Medicare:

- ☐ Part A
- ☐ Part B
- ☐ Supplemental

Senior Advantage:

- ☐ By Kaiser **
- ☐ By PacifiCare
- ☐ By Other________________________

Medi-CAL/Medi-caide:

- ☐ Straight Medical
- ☐ CCS Location: ___________________ OT: __________________________________

  PT: ____________________________

Medi-Cal Managed Care by:

- ☐ Care 1st Partner Plan
- ☐ Community Eldercare (Ex: St. Paul PACE)
- ☐ Community Health Group Partnership
- ☐ HealthNet Community Solutions
- ☐ Molina Healthcare of CA Partner Plan
- ☐ Kaiser Permanente **

IMPORTANT: Appropriate, high quality, AAC devices can be costly. Some insurance companies will cover **all, a portion, or none of the cost** of obtaining AAC device. We strongly encourage you to *contact your Member/Benefits info line* to verify the extent of your policy's benefits. AAC devices are Durable Medical Equipment (DME) like wheelchairs. Ask for details of how much DME is covered by your plan.

Is there an annual or lifetime cap (limit)? $____________
Is there an out-of-pocket maximum or deductible you must pay first? $____________
Does your plan expressly exclude coverage for speech devices? (Circle) Yes / No / Don't Know

If your contact is having trouble understanding what an AAC device is, share information about the HCPCs (Health Care Procedural Codes or "high picks") that designate certain classes of AAC devices and related equipment. The most common HCPC are E2510, E2508, E2506, E2599, and E2512

I. Medical Information:

Primary Doctor: ________________________________ Specialty: ___________________________

Address: ____

____

Phone: ____ Fax: _______________________________

Primary Medical diagnosis: _____________________________________Age of onset _________

2ndary Diagnosis: ____Age of onset _________

Speech Diagnosis: ____

Seizure History: ____

Surgeries: ____

Are challenges:

_____ developmental (since birth)

_____ acquired (due to traumatic event)

If acquired, please explain traumatic event:

____

____

Please list medications and purpose:

Medication	Purpose

II. SCHOOL INFORMATION (Ages 0-22)

Name of school/program____

Address ____

____

Phone ________________________________ Current Grade Level ___________________________

Diploma Track: _______ special diploma _______ regular diploma

What are some general activities your child participates in at school? ______________________

____

____

Is the program supportive of the use of an AAC device for the child? YES l NO

Explain:____

____

If the child's primary placement is in a SPECIAL EDUCATION classroom,

How many students are in the classroom? ________

How many assistants are in the classroom? ________

Is the child included in any general education activities? YES l NO

Explain: ____

____

If child's is in a GEN. ED. classroom, does the child have a 1:1 aide? YES l NO

Explain how the assistant works with the child: ____

____

What modifications and accommodations have been made in the classroom, to help the child to do classroom lessons? ____

____

What is the child's grade level for READING? ________________________

What is the child's grade level for SPELLING? ________________________

Is the student's writing considered functional/legible? YES l NO

III. VOCATIONAL TRAINING; DAY PROGRAM; DAILY ACTIVITIES (Ages 22+)

Are you currently receiving vocational training or attending a day program? Yes or NO

If YES, What do you do at the training or day program? ________________________________

____

____

How do you spend your day? ____

____

Do you read or write? ____

____

Do you have any experience using computers? ______________________________________

____

What do you enjoy doing for recreation/ what hobbies do you have? ____________________

____

Does you receive any ABE/ Educ. Classes at the Vocational or Day program? Yes or NO

Does the training or day program offer SLP services? Yes or NO

Is there support for those who use AAC systems at the program? YES | NO | MAYBE

IV: Physical Challenges:

Are you currently receiving any of the following services? (Check all that apply)

- ☐ Speech Therapy
- ☐ Occupational Therapy
- ☐ Physical Therapy
- ☐ Behavior supports
- ☐ After school tutoring
- ☐ Other supports

Please check all that apply:

- ☐ Can walk independently without walking aides
- ☐ Walking can be difficulty (weak, poor balance, unable to carry 4lb object)
- ☐ Can independently be mobile with walking aides (walker, cane, crutches)
- ☐ Depend on others for mobility.
- ☐ Can use power wheelchair independently
- ☐ Can use a manual wheelchair for long distances
- ☐ Can use manual wheelchair for short distances
- ☐ Require another person to push wheelchair

Do you currently use/have (check all that apply):

- ☐ a wheelchair (manual/power)
- ☐ lap tray on wheelchair
- ☐ braces (hands/feet/body)
- ☐ walker

- ☐ stander
- ☐ glasses
- ☐ hearing aid(s)
- ☐ other ______________________________

If using a wheelchair, are you well positioned and comfortable in the chair?

____

____

____

What type of chair are you currently using? ______________________________________

____

____

Do you have:

- ☐ a visual impairment
- ☐ hearing impairment
- ☐ braces on legs/arms/feet
- ☐ hearing aids
- ☐ a walker or stander
- ☐ glasses
- ☐ Other special medical concerns? ______________________________

Which body parts can you *voluntarily control*? (Check all that apply):

- ☐ Head
- ☐ Arm
- ☐ Fingers
- ☐ Elbow
- ☐ Foot
- ☐ Toe
- ☐ Fist
- ☐ Eye
- ☐ Other: ______________

How would you operate a communication device? (Check all that apply)

- ☐ point with a finger/thumb
- ☐ look at the word he/she wants
- ☐ point with his/her fist
- ☐ use a switch to scan the words
- ☐ use a light on his/her head
- ☐ point with a head stick

Does you have a dominate hand? RIGHT or LEFT

Mailing Address: 8525 Gibbs Dr. #209 San Diego, CA 92123
Fax: 619-282-5133
Website: http://www.ucpsdtechcenter.org/

IV. Communication and Interaction Skills:

During an activity do you show an understanding of the following (check all that apply):

Receptive Language Skills:	Expressive Language Skills	Communication Interaction Skills:
☐ Nouns ☐ Verbs ☐ Pronouns ☐ Adjectives ☐ Words/phrases ☐ Complete sentences ☐ 1 step directon ☐ 2 step directon ☐ 3 step direction	☐ Vocalizations ☐ semi-intelligible speech yes/no ☐ words/phrases ☐ Complete sentences ☐ full messages	☐ communicates with peers ☐ aware of partners attention ☐ asks questions ☐ repairs communication breakdown ☐ initiates communication

Can you do any of the following? Check all that apply.

- ☐ understand directions/commands
- ☐ understands yes/no questions
- ☐ understand new words
- ☐ play with people own age
- ☐ express general feelings
- ☐ express specific ideas

make choicesWhat happens to the body when you try to communicate?

____

____

Are you able answer yes/no questions? ____

____

Who best understands you and why? ____

____

Describe your ability to:

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Understand directions/ commands ____

____

Understand new words ____

____

Interact with people own age ____

____

Express general feeling: ____

____

Express specific ideas (why he/she is crying or to request for a specific participant)____

____

Make choices:____

____

Follow conversations of friends and family _____________________________________

____

Participate in social activities with friends and family ___________________________

____

Make choices between options presented? ______________________________________

____

Remember things that happened earlier in the day or week? _________________________

____

Interact with medical staff? ____

____

Talk on the telephone? ____

____

Relate stories of his/her past? ____

____

When you are trying to express a specific idea (Ex: something that happened at home), but you are NOT understood, do you:

a. realize that you are NOT understood Yes or NO
b. keep repeating until you are understood Yes or NO
c. get angry or frustrated or cry Yes or NO
d. quit and do something else Yes or NO
e. quit and stop talking Yes or NO
f. other: Yes or NO

Explain how you express:

a. happiness or sadness __ ____

____

b. are hungry or thirsty ____

____

c. need help ____

____

d. want for a specific person or object ____

____

e. want to do a specific task _____ ____

____

V. AUGMENTATIVE COMMUNICATION:

Do you already use an AAC device or mobile device with a communication app? YES l NO

If YES, please name the device/ app and who owns it: ___________________________________

____

Do you use *sign language* ? YES l NO

If YES, describe proficiency____

____

Does you have a *manual communication board, book or eye point display*? YES l NO

If YES:

a. What is the style of the manual system? ________________________________
b. What is the size of the board/book? ________________________________
c. How many words are in the board/book? ________________________________
d. How many words are there per page? ________________________________
e. How are the words represented? ________________________________
f. How does you pick a word? ________________________________
g. How long has it been used? ________________________________
h. Who uses it with him/her? ________________________________
i. How is the system transported? ________________________________
j. Who made it and/or maintains it? ________________________________

Why are you seeking more than this board, book, or display?

____

____

____

Have any other AAC device(s) been tried or suggested? YES l NO

Name of the device(1)	
How did you operate it?	
What size or how many keys were there?	
Where was it used?	
How long was it used?	
What was programmed in it?	
Is it being used now?	

If you use a wheelchair and had an AAC device in the past, how was the device transported with you?

- ☐ on the lap tray
- ☐ carried by someone
- ☐ mounted on wheelchair
- ☐ other____________________

If mounted to the wheelchair, is the mounting system for an AAC device:

a. in working order? YES l NO
b. fit the current wheelchair? YES l NO

Does you use any type of switches to operate things? YES l NO

a. What part of the body is used to activate the switch? ______________________________
b. Where are the switches located on your body/ chair?______________________________
c. How are the switches mounted or stabilized? ____________________________________

What devices are controlled with this switch? ____

____

____

How well are you able to control timing and selection at the same time? ___________________

____

____

What everyday technology or devices, does you use (or try to)? Examples: TV remote control, iPad or other similar tablet, video game, electronic toys. _________________________________

____

What specific communication questions and concerns do you want addressed during this assessment? ____

____

____

____

What long-term communication goals do you want to set? ______________________________

____

____

____

____

____

What final thoughts would you want the SLP to know?__________________________________

____

____

____

____

____

Permission

In order to ensure and effective assessment it may be helpful for UCP SD-ATC staff to videotape and/or take pictures of the consumer, which can be later reviewed by the team. The information gained may also be useful in training others in the use of assistive technology. Please check any of the following you authorize and sign below:

A) Permission for Assessment Purposes

You have my permission to

- ☐ Photograph
- ☐ Video

____for review by the assessment team.
(Consumer's name)

B) Permission for training purposes

You have my permission to

- ☐ Use photographs taken of
- ☐ Use video taken of

____ for training purposes.
(Consumer's name)

C) Denial of Permission

- ☐ I do not authorize the use of pictures or video for any use by UCP SD-ATC.

Signature

X ____
(Consumer signature)

X ____
(Parent/legal guardian signature)