CODSN ADLER'S VOICE PROGRAM
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CENTRAL OREGON DISABILITY SUPPORT NETWORK

## *GIVING EVERY CHILD THE VOICE THEY DESERVE*

Thank you for your interest in the Adler's Voice Augmentative and Alternative Communication Program.

**Who we help:**

Adler's Voice will provide assistance to children with any medical, genetic, developmental or cognitive disorder so that they may communicate to the best of their abilities. Our belief is that the ability to communicate in any way opens doors for all children and their families.

**What we do:**

Adler's Voice provides Augmentative and Alternative Communication Devices to children with significant communication disorders. Children who are non-verbal or have speech that is extremely difficult or impossible to understand are welcome to apply. **Applications requesting Assistive Technology for educational purposes will not be considered.**

**The Application Process:**

1. Complete the Adler's Voice application form. ***All fields must be completed**. Please be specific in your request and provide details about the child's current level of communication. **Application must include copies of most recent IEP and/or speech evaluation**.
2. A written recommendation for the equipment being requested is required from a physician, physical therapist, speech language pathologist, occupational therapist or educator. For your convenience, a form has been provided.
3. **Proof of income (ie: pay stubs, social security award letters, current bank statements with direct deposit, etc.) for the 30 days preceding the application the must be submitted**
4. Applications are reviewed once a quarter. Deadlines are: March 31st, June 30th, September 30th, December 31st. Applicants will be notified the month following the deadline of final decision. This process may take anywhere from 90 to 120 days. Those applications that have been approved will be notified by phone. Incomplete or ineligible applications will be notified by mail.

## GENERAL INFORMATION

All fields on this page MUST be completed for application to be accepted

Name of Applicant: _____

Address: _____

Phone # (Work) _____ (Home) _____ (Cell) _____

Medical Diagnosis: _____ Date of Onset: _____

Physician Name: _____ Phone #: _____

Date of Birth: _____ Gender: M F Age: _____

Parent or Responsible Party: _____ Relationship: _____

Email: _____

## Description of Equipment or Service Requested:

| Household Information: | |
|---|---|
| Number of Adults in Household (list below): | |
| Name: | Relationship: |
| | |
| | |
| Number of Children in Household (list below):<br>Attach separate page if necessary | |
| Name: | Relationship: |
| | |
| | |
| | |
| | |

Occupation(s) of Parents / Guardian:

Employer(s) Name: Phone #:

| Monthly Income: (All adults living in household. Be sure to attach proof of income for last 30 days) | |
|---|---|
| Gross Wages from Employment: $ | Public Assistance: (See below) $ |
| Net Wages: $ | ****OFFICE USE ONLY****<br>% FPL: |
| Social Security: $ | |

| Current Monthly Expenses: | |
|---|---|
| Housing: $ | Child Care: $ |
| Payments/Utilities (car, etc): $ | Food: $ |
| Medical: $ | Other: $ |

Public Assistance / Does the Applicant Receive:

☐ Oregon Health Plan

☐ SSI $_____.00

☐ TANF $_____.00

☐ SNAP $_____.00

☐ Other, Specify:

| Speech Language Pathologist* (*private practice, if your child receives speech services at school or EI enter that information farther down): | |
|---|---|
| Name: | |
| Clinic: | |
| Address: | |
| Phone #: | Fax #: |

| Life Skills (Special Education) Teacher: | |
|---|---|
| Name: | |
| School District: | |
| Address: | |
| Phone #: | Fax #: |

| Augmentative Communication / Assistive Technology Specialist: | |
|---|---|
| Name: | |
| Name of the Education | |
| Address: | |
| Phone #: | Fax #: |

| School or ESD Speech Language Pathologist: | |
|---|---|
| Name: | |
| Agency: | |
| Address: | |
| Phone #: | Fax #: |

In order to evaluate your application, please answer the following questions:

What assistive devices are you requesting? (Please list all items. Be specific.)

If you are requesting an iPad, what do you see as the purpose for your child in using the iPad?

Has your child had a trial period with the devices? Yes No (If yes, please describe.)

How do you see this device integrated into their academic and home environments?

What assistive technology does your child currently use?

How will the technology being requested be used at home?

Do you anticipate any barriers to implementing a communication system at home?

Will this technology be used at school? If so, how?

Have you received a commitment from the school district/ESD to support the use of the technology at school? Please provide the name, email address and phone number of the school district/ESD support person.

(iPad Only) If your child has been using the device, which AAC app(s) have they used?

How proficient is your child in using the device?

a. ___Independent

b. ___Needs adult assist to get programs set up

c. ___Needs adult monitoring to stay in the same program

d. ___Needs constant assistance

e. ___Can transport device safely from one environment to another

How proficient are you in using the device?

a. ___Very

b. ___Somewhat (might need assistance to get apps set up)

c. ___Not at all

(iPad Only) Do you have an iTunes account? (Circle One) Y N

| Description of applicant's current level of expressive communication, including which modali- |
|---|
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| Race / Ethnicity (optional): | |
|---|---|
| ☐ Asian | ☐ White |
| ☐ American Indian or Alaska Native | ☐ Other: (specify) |
| ☐ Black or African American | ☐ More than one race |
| ☐ Hispanic / Latino | ☐ I prefer not to answer |

| I have attached the following: | |
|---|---|
| ☐ Income Verification | ☐ Completed & Signed Referral from Specialist |
| ☐ Signed Release(s) | ☐ IEP and/or Speech Evaluation |

I certify that the foregoing information is true and accurate to the best of my knowledge:

Signed Relationship Date

| **OFFICE USE ONLY** | | | |
|---|---|---|---|
| Date Received: | Rating: 1 2 3<br>Need ☐ ☐ ☐ | Total Score: | Follow Up:<br>1 mo: |
| Application Complete: Y N | Trial Period ☐ ☐ ☐ | Approved: Y N | 6 mo: |
| Eligible: Y N | Tech Support ☐ ☐ ☐ | Date Notified: | 12 mo: |