

## APPENDIX A - Assistive Technology Services Application

### Bureau of Rehabilitation Services /CT Tech Act Project Description of Assistive Technology, (AT), Services

1. AT Evaluation: A full AT evaluation will include a review of records; interviews; an evaluation of a BRS consumer at the organization's center or in the community (which may include the consumer's home, BRS office or other location); an assessment and a final written report with findings and recommendations of AT device(s) and services; a list of potential vendors who may supply recommended AT device(s) and/or software and price quotes; and recommendations for amount of training, if appropriate. The report will be completed and submitted to the BRS Vocational Rehabilitation Counselor within 30 business days after the conclusion of the evaluation.
2. AT Workplace Evaluation: A Workplace Evaluation will include an evaluator traveling to a BRS consumer's work setting(s) to observe, interview and assess the consumer's functioning in the work environment. A final written report with findings and recommendations of AT device(s) and services; a list of potential vendors who may supply recommended AT device(s) and/or software and price quotes will be completed; and recommendations for amount of training, if appropriate. The report will be completed and submitted to the BRS Vocational Rehabilitation Counselor within 30 business days after the conclusion of the evaluation.
3. Home to Work Evaluation: A Home to Work Evaluation will include an evaluator traveling to a BRS consumer's home to observe, interview and assess the consumer's functioning as the consumer performs his or her daily routine and Instrumental Activities of Daily Living, (IADL). The goal is to assist the consumer in preparing for the day and exiting the home with minimum fatigue/effort to allow him or her to participate in work-related activities. This evaluation may lead to recommendations for Assistive Technology devices, Personal Care Assistant services, home modification, etc. This evaluation may also include an assessment of the Workplace as described in #2 above. A final written report with findings and recommendations of AT device(s) and services; a list of potential vendors who may supply recommended AT device(s) and/or software and price quotes will be completed; and recommendations for amount of training, if appropriate. The report will be completed and submitted to the BRS Vocational Rehabilitation Counselor within 30 business days after the conclusion of the evaluation.
4. Augmentative, Alternative Communication (AAC) Evaluation: Consumer's degree of functional speech, level of intelligibility, effectiveness of a current augmentative communication system (if current system is

- available), and receptive language skills will be evaluated to determine if an AAC device would be appropriate for the consumer. A final written report with findings and recommendations of an appropriate AAC device(s) along with a list of potential vendor(s) who may supply recommended AT device(s) and/or software and price quotes will be completed; and recommendations for amount of training, if appropriate. The report will be completed and submitted to the BRS Vocational Rehabilitation Counselor within 30 business days after the conclusion of the evaluation.
5. AT Training: AT Training will include individualized training for the BRS consumer(s) on the utilization of recommended AT device(s) and/or software. Training will take place in the environment where the AT device(s) and/or software will be primarily utilized, and as determined by the BRS Vocational Rehabilitation Counselor. Training hours will be recommended in the written reports and approved and authorized, in advance, by the BRS Vocational Rehabilitation Counselor. Upon completion of the training hours, the evaluator will provide a brief final report summarizing the results of the training and any further recommendations.
  6. AT Evaluation specific for individuals that are Deaf-Blind: A full AT evaluation with concentration on devices that are specific to individuals who are Deaf-Blind to increase their access to telecommunication services, internet access, and advanced communications. These evaluations will include recommendations of AT device(s) and/or software and recommendations for installation, customization and amount of training, if appropriate. Individuals may not be a consumer of BRS. AT Evaluations may be conducted at the consumers' home, an evaluator's office, or other location.
  7. AT Training specific to individuals that are Deaf-Blind: AT Training for this group will require experience in training deaf-blind individuals on how to use the equipment, knowledge of how to set up this equipment, and experience in ensuring that the individual can effectively use the equipment. The equipment may need to be configured to meet the specific needs of the individual. An understanding of the deaf-blind culture and the various means of communication will also be necessary. Trainers will need to be proficient in one or a combination of the following: Braille, tactile sign language, and other communication styles.

**Please note: When considering your qualifications to conduct the AT Evaluation specific for individuals that are Deaf-Blind and AT Training for individuals that are Deaf-Blind (item 6 & 7 in Appendix A), *interpreters shall be provided* by the Department, at the Departments expense, to facilitate communication barriers between the evaluator/trainer and the individual.**

Respondents selected must agree to provide contracted services at the rate outlined in the Fee for Service Table, below.

Mileage, from business to evaluation site, is determined by Mapquest.com and is reimbursed at a rate of .555 cents per mile.

Reimbursement schedule to contractor is 45 days from receipt of invoice to DORS.

AT SERVICES	RATE	MAXIMUM HOURS (additional hours require prior approval)
a. AT Evaluation	\$100./hour	5 hours Includes: Interviews, hands on evaluation and report with recommendations
b. AT Workplace Evaluation	\$100./hour	5 hours Includes: Interviews, hands on evaluation and report with recommendations
c. Home to Work Evaluation	\$100./hour	5 hours Includes: Interviews, hands on evaluation and report with recommendations
d. Augmentative, Alternative Communication (AAC) Evaluation	Medicaid rate/hour	Determined by Medicaid
e. AT Training	100./hour	Hours approved by Program Staff prior to completion
f. AT Evaluation specific for individuals that are Deaf-Blind	\$100./hour	5 hours Includes: Interviews, hands on evaluation and report with recommendations
g. AT Training specific to individuals that are Deaf-Blind	\$100./hour	5 hours Includes: Interviews, hands on evaluation and report with recommendations

Bureau of Rehabilitation Services / CT Tech Act Project  
Assistive Technology Evaluator Application

**A. DEMOGRAPHICS**

**A1. ORGANIZATIONAL DEMOGRAPHICS - complete this section if the Respondent is an employer of one or more employees**

Name of Organization/Provider:		
Organization d.b.a name:		
Address:		
Phone:	Fax:	Email:
SS#/Fed. I.D.:		Administrative/Executive Director Name:
Payment Address (if different):		
Are you incorporated: <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you a: <input type="checkbox"/> For Profit <input type="checkbox"/> Not for Profit <input type="checkbox"/> Non-Profit
Name of Contact Person for AT Services: <i>(This individual will assume the role of being responsible for all administrative supervision of AT services of the organization.)</i>		
Phone:		Email:

**A2. INDIVIDUAL DEMOGRAPHICS - complete this section if the Respondent is a single provider of services**

Name:		
Address:		
Phone:	Fax:	Email:
SS#/Fed. I.D.:		
Payment Address (if different):		
Are you incorporated: <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you a: <input type="checkbox"/> For Profit <input type="checkbox"/> Not for Profit <input type="checkbox"/> Non-Profit
Phone:		Email:

**B. SERVICE AREAS - complete this section if the Respondent is an Organization or an Individual**

Check the areas of interest to serve:

\_\_\_\_\_Region 1: Avon, Bloomfield, Canton, East Granby, Farmington, Granby, Hartford, Newington, Rocky Hill, Simsbury, Suffield, West Hartford, Wethersfield, Windsor, Windsor Locks, Andover, Bolton, East Hartford, East Windsor, Ellington, Enfield, Glastonbury, Hebron, Manchester, Marlborough, Somers, South Windsor, Stafford, Tolland, Vernon

\_\_\_\_\_Region 2: Berlin, Bristol, Burlington, New Britain, Plainville, Plymouth, Southington

\_\_\_\_\_Region 3: Ashford, Brooklyn, Canterbury, Chaplin, Columbia, Coventry, Eastford, Hampton, Killingly, Mansfield, Plainfield, Pomfret, Putnam, Scotland, Sterling, Thompson, Union, Willington, Windham and Woodstock.

\_\_\_\_\_Region 4: Ansonia, Bethany, Branford, Derby, East Haven, Hamden, Milford, New Haven, North Branford, North Haven, Orange, Seymour, Shelton, Wallingford, West Haven and Woodbridge

\_\_\_\_\_Region 5: Bozrah, Colchester, East Lyme, Franklin, Griswold, Groton, Lebanon, Ledyard, Lisbon, Montville, New London, North Stonington, Norwich, Preston, Salem, Sprague, Stonington, Voluntown, Waterford

\_\_\_\_\_Region 6: Chester, Clinton, Cromwell, Deep River, Durham, East Haddam, East Hampton, Essex, Guilford, Haddam, Killingworth, Lyme, Madison, Meriden, Middlefield, Middletown, Old Lyme, Old Saybrook, Portland, Westbrook

\_\_\_\_\_Region 7: Bridgeport, Easton, Fairfield, Monroe, Norwalk, Stratford, Trumbull, Weston, Westport, Darien, Greenwich, New Canaan, Stamford, Wilton

\_\_\_\_\_Region 8: Beacon Falls, Cheshire, Middlebury, Naugatuck, Oxford, Prospect, Southbury, Waterbury, Watertown, Wolcott

\_\_\_\_\_Region 9: Bethel, Bridgewater, Brookfield, Danbury, New Fairfield, New Milford, Newtown, Redding, Ridgefield, Sherman

\_\_\_\_\_Region 10: Barkhamsted, Bethlehem, Canaan, Colebrook, Cornwall, Goshen, Hartland, Harwinton, Kent, Litchfield, Morris, New Hartford, Norfolk, North Canaan, Roxbury, Salisbury, Sharon, Thomaston, Torrington, Warren, Washington, Winchester, Woodbury

C. EXPERIENCE - complete this section if the Respondent is an Organization or an Individual.

THE RESPONDENT SHALL:

1. Describe the Assistive Technology related service(s) currently being provided:

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2. Describe the disability population(s) primarily being served, including consumer age groups, etc.: Page limitation is one (1) single-sided page

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3. Check the AT services interested in providing?

- Assistive Technology Evaluation
- AT Workplace Evaluation
- Home to Work Evaluation
- AAC Evaluation
- AT Training
- AT Evaluation for individuals who are deaf-blind
- AT Training for individuals who are deaf-blind
- Other, please explain: \_\_\_\_\_

4. Check other languages or formats that services can be provided:

- Spanish
- American Sign Language
- Tactile Sign Language
- Braille
- Other, please explain: \_\_\_\_\_

5. Describe the ability to work with persons who are hearing impaired, persons who are deaf-blind, persons who have limited language skills and persons whose primary language is not English. Describe how the Respondent ensures cultural competency.

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**D. SERVICES PROVIDED IN BUILDING OWNED OR RENTED - complete this section if the Respondent is an Organization or Individual.**

1. Does your organization, or do you, as an Individual, have a facility where AT services can take place?  Yes  No

If yes, please describe the facility and the types of AT services that can take place there, i.e.: evaluations, trainings, etc. **Page limitation is one (1) single-sided page**

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2. Is the facility fully accessible? Check all that apply:

Entrance/Exit

Elevator

Parking

Bathroom(s)

Other, please explain: \_\_\_\_\_

3. Describe the proximity to public transportation of each location at which the Respondent proposes to provide Services. **Page limitation is one (1) single-sided page**

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**E. RISK ASSESSMENT / MANAGEMENT - If the Respondent is an Organization, complete 1- 4.  
If the Respondent is an Individual, complete 1-3.**

**(Attach any policy and procedures you may have developed to address the areas below)**

1. Describe how the Respondent will ensure that the health, safety, rights, and confidentiality of individuals receiving services will be protected, including how the Respondent will prevent abuse, neglect, and exploitation. **Page limitation is one (1) single-sided page**

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2. Describe how the Respondent identifies, controls, avoids, minimizes and/or eliminates unacceptable risks and liability to the Respondent. Page limitation is one (1) single-sided page

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3. Describe how the Respondent protects the security of individuals and their information. Page limitation is one (1) single-sided page

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4. Describe how your organization prevents, identifies, and reports abuse, neglect, exploitation and rights violations, including the training of staff on these issues. Page limitation is one (1) single-sided page

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**F. ADVERSE/DISCIPLINARY ACTIONS - complete this section if the Respondent is an Organization or an Individual**

Please provide a full explanation for any "Yes" responses: Page limitation is one (1) double sided page for F. 1.-10.

1. Has the Respondent ever been a party to a contract or held an employee position that was terminated for cause, relinquished or withdrawn; or failed to proceed with an application to avoid an adverse action, to preclude an investigation, or while under investigation relating to professional conduct?  Yes  No
2. Has participation in Medicare, Medicaid, or other government programs as a Provider ever been or is it currently in the process of being denied, revoked, suspended, reduced, limited, censured, placed on probation, reprimanded, sanctioned, disqualified, fined, placed under board order, or not renewed?  Yes  No

3. Has the Respondent ever been assessed a penalty by Medicaid, Medicare or any other government program?  Yes  No
4. Has the Respondent ever been convicted of or pleaded no contest to any criminal felony charges?  Yes  No
5. Has the Respondent ever been convicted of or pleaded no contest to a drug or alcohol related offense?  Yes  No
6. Has the Respondent ever been sanctioned by a peer review organization or similar federal, state, regulatory program or military agency?  Yes  No
7. Has the Respondent ever been found to be the perpetrator of a confirmed case of client abuse or neglect or exploitation?  Yes  No
8. Is the Respondent currently under investigation, or has the Respondent had a license or accreditation revoked, by any state/federal/local authority or licensure agency, within the last five (5) years?  Yes  No
9. Has the Respondent had any judgments or settlements entered against it in the last ten (10) years?  Yes  No
10. Has the Respondent been placed on vendor hold within the past five (5) years by any funding agency or company?  Yes  No

**G. REFERENCES complete this section if the Respondent is an Organization or an Individual**

List three references for Organization or for the Individual, as the Respondent. At least one (1) reference must be able to attest to work behavior. At least two of the references must be persons not related to the applicant by blood or marriage and must have knowledge of the Respondent's previous experience and ability to provide a healthy, safe, and therapeutic environment to Consumers serviced under this RFA:

NAME	E-MAIL ADDRESS	PHONE NUMBER

**H. A responsive submission must also include the following documents:**

If the Respondent is an Organization:

1. Provide current resumes of existing staff and/or job descriptions of the proposed staff to conduct services; and
2. Provide copies of current and valid Motor Vehicle Operator's license / Driver Identification and a copy of Automobile Insurance Policy Declaration Page of existing staff to conduct services.

If Respondent is an Individual:

1. Provide resume of the Individual; and
2. Provide a copy of current and valid Motor Vehicle Operator's license / Driver Identification and a copy of Automobile Insurance Policy Declaration.