



## Assistive Technology Trial/Implementation Plan

Student: \_\_\_\_\_ School: \_\_\_\_\_ Date: \_\_\_\_\_

Team Members Participating: \_\_\_\_\_

Tools to be used: \_\_\_\_\_

Goal for Assistive Technology Use (related to IEP goal/objective):

\_\_\_\_\_  
\_\_\_\_\_

How will we know if the trial is successful?

\_\_\_\_\_  
\_\_\_\_\_

What are some indicators that would prompt the team to adjust the plan/tool?

\_\_\_\_\_  
\_\_\_\_\_

Date & location for follow up meeting: \_\_\_\_\_

Other Notes:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Assistive Technology Trial/Implementation Plan, Cont.**

<b>Support Task</b>	<b>Person Responsible (List name and phone #)</b>	<b>Schedule (List date(s)/days/frequency)</b>	<b>Evidence of Completion (Where will evidence be documented?)</b>
Initial Student Training			
Ongoing Student Training			
Daily/Regular Support of Use:			
Environment & Task 1:			
Environment & Task 2:			
Environment & Task 3:			
Environment & Task 4:			
Environment & Task 5:			
Daily/Regular Maintenance Activ.			
Staff Training (list staff)			
Communication with Family			
Parent/Family Training			
Repairs and Modifications			