

Easterseals Massachusetts

MRC Assistive Technology Independent Living Program

Email completed form to: ATIL@eastersealsma.org

508-471-1400

**Please note: If the client is currently receiving services from the following MRC Programs: Supported Living, Home Care, Statewide Head Injury Program, please use this link for referrals:** [MRC Community Living Referrals](https://forms.office.com/pages/responsepage.aspx?id=Fh2GPrdIDkqYBowE2Bt7KkGktFVFa_5CtQ6viMwWvhJUREVTSzFBVDVIU1VRTURURlpVVEZGVVIxSi4u)

**Applicant Information**

|  |  |  |
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| **Client Name**:       | **Birthdate**:       | Pronouns:       |
| **Address**:       |
| **City**:       | **State**:       | **Zip**:       |
| **Email**:       | **Phone**:       | **Alt Phone**:       |
| **Current living arrangement (check all that apply)**[ ] In apartment/home in the community [ ] Group home [ ] Inpatient facility [ ] Lives alone [ ] Lives with others |
| **Do you have an affiliation with the armed forces? (check all that apply)**[ ] Active duty [ ] National Guard/Reserve [ ] Veteran [ ] Member military/veteran family [ ] No affiliation [ ] Prefer not to say |
| **Would you be willing to share your story with community partners who support our services?** [ ] Yes [ ]  No  |
| **Who should be contacted to schedule an evaluation?** **Name:**       | **Phone**:       | **Alt Phone**:       |

**Person Making Referral** (If applicable)

|  |  |  |
| --- | --- | --- |
| **Person Making Referral**:       | **Agency/Office**:       | **Relationship:**       |
| **Address**:       |
| **City**:       | **State**:       | **Zip**:       |
| **Email**:       | **Phone**:       |

**Programs/Services of Interest (check all that apply)**

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| [ ]  The *Assistive Technology Independent Living* program: A free program providing in-home assessment, device purchase, and setup/training support for qualifying individuals in the Boston, Central MA, Northeast MA, and Southeast MA areas. |
| [ ]  Augmentative Communication Services |
| [ ]  Assistive Technology Services in a School System |
| ☐ Private Pay Services  |
| ☐ Uncertain which program/service is the best fit |

**Applicant Background**

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| **Please describe any relevant medical history:**       |
| **How does the applicant’s medical history impact daily functioning?**       |
| **What are the applicant’s goals for using assistive technology?**      |
| **Are there specific types of technology requested? If so, please describe**:       |
| **Is the client currently using any assistive technology? If so, please describe**:       |
| **Is there an support network that can provide long term technical support for the assistive technology?**[ ]  **Yes** [ ]  **No** [ ]  **Maybe**       |
| **Is the client currently receiving services from other state agencies such as MRC Vocational Rehab, MRC Supported Living, Mass Commission for the Blind, Mass Commission for Deaf and Hard of Hearing or Department of Developmental Services?**       |
| **Additional comments**      |