



A Voice Discovered

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## A Voice Discovered Individual Grant Application

Date of application: \_\_\_\_\_

### Personal Information

First name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_

Gender: \_\_\_\_\_

Disability: \_\_\_\_\_

Ethnicity (optional): \_\_\_\_\_

Birthplace: \_\_\_\_\_

Language(s) spoken in the home: \_\_\_\_\_

### Address

Place of Residence: (e.g., home, group home, skilled nursing facility, assisted living, custodial care facility, other): \_\_\_\_\_

Name of facility: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Does the client attend School or a day program? \_\_\_\_ Yes \_\_\_\_ No

Name of School/Day Program: \_\_\_\_\_

## Contact Person/Client Advocate Information

First name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Relationship to client: \_\_\_\_\_

Name of Facility: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_

Work Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Best Way to Contact: (circle one)    Email    Phone

Best Time to Contact: (circle one)    Morning    Afternoon    Evening

## How can AVD help?

Please check-off the following services of interest

### ☐ Information

- ☐ What is AAC?
- ☐ AAC Assessment
- ☐ AAC Therapy
- ☐ AAC Camps
- ☐ Funding sources for AAC

### ☐ Funding Assistance

- ☐ AAC Assessment
- ☐ AAC device
- ☐ AAC therapy
- ☐ AAC training (e.g., for staff, family, etc.)
- ☐ AAC Camp attendance

## Current Communication System

Does the client currently own or have access to a device? Yes\_\_\_\_No\_\_\_\_

To whom does the device belong?\_\_\_\_\_

**Device manufacturer** (e.g., Prentke Romich, Tobii/Dynavox, Salitllo, Attainment Company, Apple – iPad/iPhone):\_\_\_\_\_

**Name of Device/App** (e.g., Vantage Lite, Maestro, Tobii C8, Proloquo2go, Touchchat, Go Talk Now):\_\_\_\_\_

**Purchase Date of Device/App:**\_\_\_\_\_

**How many years has the client used the device/app?**\_\_\_\_\_

**What other forms of communication does the client use (e.g., pictures, PECS book, sign language, gestures, vocalizations, speech, etc.):**

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

## AAC (Augmentative and Alternative Communication) Assessment Information:

Has the client had an AAC assessment? Yes\_\_\_\_ No \_\_\_\_

If no, have you asked for an AAC assessment through one of the following agencies: the school district, Regional Center, the MTU, private insurance? (depending on which is applicable)

Yes\_\_\_\_ No\_\_\_\_

Please explain:\_\_\_\_\_

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

If yes, when was the AAC assessment completed? \_\_\_\_\_  
(\*An assessment is considered current if completed within the last 12 months.)

Who completed the AAC assessment? \_\_\_\_\_

What were the recommendations? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you agree with the assessment results? Yes \_\_\_\_\_ No \_\_\_\_\_

Please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Was a device or iPad and communication app purchased as a result of the assessment?

Yes \_\_\_\_\_ No \_\_\_\_\_

Please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If yes, who purchased the device or iPad and communication app? \_\_\_\_\_

\_\_\_\_\_

If you did not agree with the first assessment, has the client received a 2<sup>nd</sup> opinion AAC assessment? Yes \_\_\_\_\_ No \_\_\_\_\_

When? \_\_\_\_\_

By Whom? \_\_\_\_\_

What were the recommendations? \_\_\_\_\_

\_\_\_\_\_

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Do you agree with the assessment results? Yes \_\_\_\_\_ No \_\_\_\_\_

Please explain: \_\_\_\_\_

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Was a device or iPad and communication app purchased as a result of the assessment?

Yes \_\_\_\_\_ No \_\_\_\_\_

Please explain: \_\_\_\_\_

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When? \_\_\_\_\_

By whom? \_\_\_\_\_

## **AAC/Speech and Language Therapy**

Does the client currently receive speech and language therapy from a licensed speech and language pathologist? Yes \_\_\_\_\_ No \_\_\_\_\_

Where? \_\_\_\_\_

By whom? \_\_\_\_\_

How often? \_\_\_\_\_

What are the client's goals? \_\_\_\_\_

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Name of SLP? \_\_\_\_\_

SLP phone number: \_\_\_\_\_

SLP email address: \_\_\_\_\_

Does the client need an SLP specializing in AAC? Yes \_\_\_\_\_ No \_\_\_\_\_  
(AVD will provide a list of SLPs who specialize in AAC)

How many sessions were recommended? \_\_\_\_\_

How many sessions have been received? \_\_\_\_\_

Do you think more sessions are needed? Yes \_\_\_\_\_ No \_\_\_\_\_

Please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## **AAC Equipment**

What AAC equipment is being requested? (iPad, iPad case, mount, AAC app, etc.)

\_\_\_\_\_

What is the cost? \_\_\_\_\_

Have other funding sources been contacted to request funding of this item or items  
(e.g., private insurance, CCS, Medi-cal, TCRC, etc.)?

Yes \_\_\_\_\_ No \_\_\_\_\_

What was the outcome? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If requesting funding for AAC devices, iPads and/or Apps, a recent AAC assessment must have been completed by an SLP with AAC experience. Please provide a copy of the most recent AAC assessment and recommendations. If an AAC assessment is needed, please indicate in the section above.

## **AAC Device/Communication App Training**

Has the client's family, caregivers, home therapists, school/day program staff been trained on the device? Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, when?\_\_\_\_\_

How many hours?\_\_\_\_\_

If yes, do you think more training is needed? Yes\_\_\_\_\_ No\_\_\_\_\_

Please explain:\_\_\_\_\_

\_\_\_\_\_

Who would benefit from training?\_\_\_\_\_

\_\_\_\_\_

What specific training needs?\_\_\_\_\_

\_\_\_\_\_

## **AAC Camp Funding**

Do you already have an AAC camp in mind for the client? Yes\_\_\_\_\_ No\_\_\_\_\_

If no, do you need information about AAC camps? Yes \_\_\_\_\_ No\_\_\_\_\_

## **Camp Contact Information**

Camp Name: \_\_\_\_\_

Camp Location:\_\_\_\_\_

Contact person: \_\_\_\_\_

Phone Number:\_\_\_\_\_

Email Address:\_\_\_\_\_

Webpage:\_\_\_\_\_

## **Camp Cost**

What is the cost to attend the camp? \_\_\_\_\_

What is the cost of travel expenses? \_\_\_\_\_

How much is being covered? \_\_\_\_\_

How much is needed? \_\_\_\_\_

## Funding Sources

The client has access to the following funding sources:  
(check all that apply)

- ☐ Private Insurance  
Name of Insurance Company \_\_\_\_\_
- ☐ Medi-Cal
- ☐ Medicaid
- ☐ Medicare
- ☐ CCS (California Children's Services) Medi-cal
- ☐ Tri-counties Regional Center
- ☐ School District
- ☐ Local Charity
- ☐ Grant
- ☐ Out of pocket
- ☐ Other: \_\_\_\_\_

## Justification:

Please describe the person with complex communication needs, how the person with complex communication needs currently communicates, and how they would benefit from assistance and support from A Voice Discovered Inc. (attach additional pages as necessary).

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**Estimated Overall Cost** \_\_\_\_\_

**If you have any questions about the application, please email:**

[info@avoicediscovered.com](mailto:info@avoicediscovered.com)

**\*\*Please attach a copy of the most recent AAC report(s) if applicable**

<b>AVD Use:</b>
Date received:
Called Contact Person:
Notes: