



TECHNICAL ASSISTANCE REQUEST FORM

Instructions: Please check and update all information for accuracy. Once you fill out all fields, we recommend that you print a hard copy.

Your Name: (first, middle initial, surname)	Agency:
Address:	Daytime Phone #:
Name of Child in Need of Assistance:	Date of Birth: (m/d/y) Male <input type="checkbox"/> Female <input type="checkbox"/>
Address:	Your Relationship to Child:

What Type of Technical Assistance Interests Might Fill Your Needs?

- | | |
|---------------------------------------|---|
| <input type="checkbox"/> In-service | <input type="checkbox"/> Phone contact |
| <input type="checkbox"/> Home visit | <input type="checkbox"/> Recommendations for information and/or resources |
| <input type="checkbox"/> School visit | <input type="checkbox"/> Other (specify) |

What Topics Would You Like Addressed?

Topics	Comments
<input type="checkbox"/> Auditory Training/Listening Skills	
<input type="checkbox"/> Assessment Information and/or Referral (if form is printed and mailed, please circle area: vision, hearing, communication, development or other)	
<input type="checkbox"/> Behavior Management/Social Emotional Concerns (relationship with others)	
<input type="checkbox"/> Communication System Development	
<input type="checkbox"/> Daily Living Skills (personal care and self-help skills such as toileting, dressing, etc.)	

<input type="checkbox"/> Friendship Facilitation	
<input type="checkbox"/> Home or Classroom	
<input type="checkbox"/> IEP Development/Person-Centered Planning	
<input type="checkbox"/> Inclusion into School Program (techniques that support the child's learning in the regular classroom)	
<input type="checkbox"/> Literacy Mode Determination (use of braille, large print, etc.)	
<input type="checkbox"/> Medical Issues (gaining more information about a child's diagnosis)	
<input type="checkbox"/> Orientation and Mobility Skills (travel independence)	
<input type="checkbox"/> Organizing a Daily Routine (sequence of activities, transition from one activity to another)	
<input type="checkbox"/> Parent to Parent Contact	
<input type="checkbox"/> Recreation and Leisure Skills	
<input type="checkbox"/> Resources: Information and/or Referral	
<input type="checkbox"/> Sensory Skill Development (vision, hearing, tactile skill use)	
<input type="checkbox"/> Transition (early childhood to school or school to adult services)	
<input type="checkbox"/> Vocational Training/Employment	
<input type="checkbox"/> Other (specify)	

Submit Electronically OR Print and Mail Form to address below.



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