

**Nathaniel H. Kornreich  
Technology Center  
REFERRAL PACKET FOR  
ASSISTIVE TECHNOLOGY SERVICES**

This Referral Packet contains the following:

- List of *Materials to be Submitted with a Referral*.
- An *Authorization of Services/Payment Agreement* form.
- A *Release of Information Form*.  
Completion and return of these two forms or acceptable substitutes is required before services can begin.
- *Screening Forms (2)*. One to be filled out by the consumer who needs assistive technology and one by the person or agency making the referral. Instructions are on each form.
- A *Photo Release* form. As part of our mission, the Kornreich Technology Center creates educational materials and conducts educational programs related to assistive technology for people with disabilities. Visual documentation of consumers testing and using assistive devices are a valuable part of such education. We may request permission to photograph or videotape your activities at the center. See form for more information.
- A fee list describing services offered to individual consumers.

*You may copy these forms as needed for future use.*

**REGARDING CANCELLATIONS:**

*Demand for our services varies and at times consumers are placed on a waiting list. When consumers do not keep appointments, completion of their evaluations is delayed, extending the time others must wait. Therefore, it is our policy that the second time a consumer fails to keep an appointment or cancels with less than 24 hours notice, the consumer's services may be suspended and his or her name returned to the end of the existing waiting list.*

## Materials to be Submitted with a Referral

When submitting a referral to the **Kornreich Technology Center**, please be sure the referral packet contains the following forms and reports:

- ✓ **Acceptance of Service and Payment Agreement form or authorization letter**  
If you prefer to send a letter instead of using the Kornreich Center form, please ensure that the letter contains the same information as the form, including the applicable hourly rate(s) for the services requested.
- ✓ **Release form**  
Specifying to whom the evaluation report should be submitted, and authorizing the Kornreich Center to release information to those individuals or agencies (or denying such authorization).
- ✓ **Consumer Screening form – Self**  
To be completed by the consumer, or by a parent or other person familiar with the consumer's needs for assistive technology. This form gives us the *consumer's* perspective on the purpose of the evaluation, barriers to achieving goals, and environment(s) in which the technology will be used.
- ✓ **Consumer Screening form – Other**  
To be completed by the person at the agency initiating the referral who is most familiar with the consumer's need for assistive technology, such as a teacher, therapist, or personal attendant. Input from more than one professional is welcomed, either on the same or separate forms. If information requested is *specifically* addressed in one of the background reports (see below), write "see [OT/PT, etc.] report, enclosed" in the appropriate places on this form.
- ✓ **Background reports**  
The more information we have about the consumer's current abilities, environment (human and non-human), goals, and past experiences relevant to technology, the better we will be able to plan and conduct the evaluation and, usually, the less time the evaluation will take. Please submit the most current reports, if they exist for this consumer:
  - Previous assistive technology evaluation report
  - IEP/IFSP/ITP/IWRP
  - Occupational therapy report
  - Physical therapy report
  - Speech therapy report
  - Vocational evaluation report or plan
  - Functional vision/Vision report
  - Medical reportEducational, neuropsychological or psychological evaluation report

Authorization of Services and Payment Agreement

Person receiving services

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

- Referring agency: [ ] ACCES-VR District office: [ ] School district: [ ] Other:

Contact person: Name: Relationship to consumer: Phone: Fax: E-mail:

Services to be provided

- Assistive technology evaluation or consultation \$ 175/hr.
Optional written justification \$ 300.
Optional follow-up meeting \$ 175/hr.
Planning meetings or other substantive contacts \$ 175/hr.
Preparation and delivery of training, individual or group \$ 175/hr.
Technical setup/modification/support \$ 175/hr.
Ancillary services \$ 100/hr.
Travel time \$ 60/hr.
AT screening - up to 1 hour \$ 175.

Payment: Services are billed monthly, except by special arrangement.

Party responsible for payment

Name: Title: Agency: Address: e-mail: Phone: Fax:

Signature of responsible party

Date

## -- THIS FORM TO BE COMPLETED BY PAYER ONLY -- RELEASE OF INFORMATION FORM

The Kornreich Technology Center normally exchanges information about a consumer's service here only with the person or agency financially responsible for those services. Written recommendations and reports will be sent to that person or agency. The financially-responsible party should complete the relevant lines below, and sign the form.

Date: \_\_\_\_\_ Consumer's name: \_\_\_\_\_

Do not share information with anyone but the party financially responsible.  
OR

I give permission to the Nathaniel H. Kornreich Technology Center at Abilities! to release any necessary information or records concerning assistive technology services received at the Kornreich Center to:

Consumer/parent/family member Address: \_\_\_\_\_

Name, relationship: \_\_\_\_\_

School/district staff: \_\_\_\_\_ Address: \_\_\_\_\_

Name or title of person: \_\_\_\_\_

Other: \_\_\_\_\_ Address: \_\_\_\_\_

\_\_\_\_\_

I, or the agency I represent: \_\_\_\_\_  
am financially responsible for the services provided to this consumer.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print name clearly: \_\_\_\_\_

Title within paying agency: \_\_\_\_\_

Special instructions or limitations (if any): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**ASSISTIVE TECHNOLOGY EVALUATION  
SCREENING FORM - CONSUMER**

**To be completed by you, the consumer, a family member, or someone in your personal life familiar with your need for assistive technology.** This information will be used to help us prepare for your evaluation. If you have questions about how we use it, please ask us at any time.

Please make your answers as **SPECIFIC** as possible; circle more than one choice when appropriate; feel free to write additional information in the margins and on additional paper. **The more we know about your abilities and goals, the more efficient your evaluation will be, and the better the result.**

Your last name: \_\_\_\_\_ First name: \_\_\_\_\_ Today's date: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Male/Female Address: \_\_\_\_\_

Phone: \_\_\_\_\_ e-mail: \_\_\_\_\_

Person completing this form: self / parent (name) \_\_\_\_\_ / other (specify) \_\_\_\_\_

**PURPOSE OF EVALUATION:**

What kind of assistive technology are you seeking?

Augmentative communication / Computer access / Other (describe below)

**IMPORTANT:** Describe the problems assistive technology may help you with. What do you expect or hope assistive technology will enable you to do that you cannot do now? (Add additional paper as needed)

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

If you have any assistive technology now, describe it: \_\_\_\_\_

Do you use it? Yes /No If not, why not? \_\_\_\_\_

What problems (if any) do you have with it? \_\_\_\_\_

\_\_\_\_\_

If you've had a previous assistive technology evaluation, state:

Date: \_\_\_\_\_ Where: \_\_\_\_\_

For what kind of technology?

Augmentative communication / Computer access / Other: \_\_\_\_\_

*(If there was a written report, please attach a copy, or make arrangements for us to receive a copy.)*

**PERTINENT BACKGROUND INFORMATION**

**Diagnosis:** \_\_\_\_\_ **How long have you had this diagnosis?** \_\_\_\_\_

If you take **medication**, what is it for? \_\_\_\_\_

List any **safety** issues we should know about (e.g., ventilator, seizures, etc.) \_\_\_\_\_

Any **vision** problems? (describe): \_\_\_\_\_ **Glasses?** Yes / No

Any **hearing** problems? (describe): \_\_\_\_\_ **Hearing aid?** Yes/No

**Walking:** Walk independently / Walk assisted (describe) \_\_\_\_\_ / Don't walk

**Wheelchair:** Power chair or scooter / Manual chair / None Self propel? Yes / No Laptray? Yes / No

If chair will be replaced soon, When? \_\_\_\_\_ Why? \_\_\_\_\_

**Hand function:** Right handed/Left handed Weakness, tremor, paralysis, or other problems?

(describe) \_\_\_\_\_

Can you: Hold a pen? Yes / No Feed yourself? Yes / No / Need help  
 Press buttons (as on a telephone)? Yes / No Comb your hair? Yes / No / Need help

**Communication:** Speech impairment? (describe) \_\_\_\_\_

What is your primary language? \_\_\_\_\_ Other language(s): \_\_\_\_\_

**Cognition:** Any problems with memory?: Short term / Long term  
 Any trouble following directions? Rarely or never / Occasionally / Often  
 Any trouble concentrating or sticking to a task? Rarely or never / Occasionally / Often

**Education:** Highest level completed: \_\_\_\_\_ In school now or soon? Yes / No  
 Do you have trouble: Reading? Yes / No Doing basic arithmetic? Yes / No  
 Do you have a learning disability? Yes / No What type? \_\_\_\_\_

Do you have a personal care attendant? Yes / No If so, how often? \_\_\_\_\_

When was the last time you received any:

Occupational therapy	Never / Over a year ago / Less than a year ago / Receiving now or soon
Speech/language therapy	Never / Over a year ago / Less than a year ago / Receiving now or soon
Physical therapy	Never / Over a year ago / Less than a year ago / Receiving now or soon
Vocational eval./training	Never / Over a year ago / Less than a year ago / Receiving now or soon
Other rehab/therapy	Never / Over a year ago / Less than a year ago / Receiving now or soon

describe: \_\_\_\_\_

**COMPUTER ACCESS SCREENING INFORMATION**  
**To be completed ONLY by consumer seeking COMPUTER ACCESS services**  
(see next page for Augmentative Communication section)

What do you want to use a computer for?

Word processing / Graphics / Internet / Education / Other (specify): \_\_\_\_\_

Do you own a computer now? If so, what type? \_\_\_\_\_

How much experience do you have with personal computer applications?

Word processing	Almost none / A little / Quite a bit / A lot
Computer graphics	Almost none / A little / Quite a bit / A lot
Internet	Almost none / A little / Quite a bit / A lot
Educational programs	Almost none / A little / Quite a bit / A lot
Games	Almost none / A little / Quite a bit / A lot
Other: _____	Almost none / A little / Quite a bit / A lot

What SPECIFIC difficulties have you had (or do you expect to have) with using a computer because of your disability? (For example: arm gets tired; can't read screen; hit 2 keys at once ; mouse moves when pressing button; etc.) **Describe ALL difficulties:**

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

Describe any special computer equipment or software you have used because of your disability (For example: special keyboard, left-handed mouse, typing stick, keyboard tray; talking word processor, etc.)

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

Do you have pain when you use a computer? Don't know/No/Yes (where): \_\_\_\_\_

How long before pain starts? \_\_\_\_\_ How long before you stop due to pain? \_\_\_\_\_

Have you been treated for the pain? No / Yes What does the doctor say? \_\_\_\_\_

\_\_\_\_\_

Where will you use the computer? (circle all that apply)

A) Home / Work / School / Other \_\_\_\_\_

B) Lying on bed, couch / Standing / Office chair / Kitchen-type chair / Easy chair, couch / Wheelchair

C) Computer will be on: A desk / A table / In lap / A computer workstation / On laptray

**AUGMENTATIVE COMMUNICATION SCREENING INFORMATION**  
**To be completed ONLY by consumer seeking AUGMENTATIVE COMMUNICATION services**  
(see previous page for Computer Access section)

**Current methods of communication (circle all that apply):**

- Speech
- Yes-no responses
- Gestures, facial expressions
- Manual communication board
- Electronic communication device (name) \_\_\_\_\_
- Other: \_\_\_\_\_
- Sounds
- Sign language
- Writing
- Eye gaze

**Who can understand your communication, and how well?**

- Strangers      Nearly always / Part of the time / Almost never / (not applicable)
- Teachers      Nearly always / Part of the time / Almost never / (not applicable)
- Peers, friends      Nearly always / Part of the time / Almost never / (not applicable)
- Parents      Nearly always / Part of the time / Almost never / (not applicable)
- Siblings      Nearly always / Part of the time / Almost never / (not applicable)
- Other      Nearly always / Part of the time / Almost never / (not applicable)

**What do you do when you are not understood (circle all that apply)?**

- Keep trying to communicate same message
- Get angry
- Stop trying to communicate
- Change message to make yourself understood
- Get someone who understands you to translate
- Other: \_\_\_\_\_

**Does your communication problem affect your: Social life? / Work or school life? / Family life?**

**Describe the effect:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**If you have an electronic communication device:**

**Do you use it? Yes /No If not, why not? What problems (if any) do you have with it?**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ASSISTIVE TECHNOLOGY EVALUATION  
SCREENING FORM – REFERRAL AGENCY**

**To be completed by the person making this referral, or other professional familiar with the consumer's need for assistive technology.** This information will be used to help us prepare for the evaluation. If you have questions about how we use it, please ask us at any time.

Please make your answers as **SPECIFIC** as possible; circle more than one choice when appropriate; write additional information on additional paper. **The more we know about the consumer's abilities and goals, the more efficient the evaluation will be, and the better the result.**

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ Today's date: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Male/Female Address: \_\_\_\_\_

Ph: \_\_\_\_\_ e-mail: \_\_\_\_\_

Person completing this form: \_\_\_\_\_ Relationship to consumer: \_\_\_\_\_

**PURPOSE OF EVALUATION:**

What kind of assistive technology does the consumer need?

Augmentative communication / Computer access / Other (describe below)

**IMPORTANT:** Describe the problems assistive technology may help with. What do you expect or hope the consumer will be able to **do** with assistive technology that s/he cannot do now? (Add paper as needed)

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

If s/he has any assistive technology now, describe it: \_\_\_\_\_

Does s/he use it? Yes /No If not, why not? \_\_\_\_\_

What problems (if any) are there with it? \_\_\_\_\_

\_\_\_\_\_

If the consumer had a previous assistive technology evaluation, state:

Date: \_\_\_\_\_ Where: \_\_\_\_\_

For what kind of technology?

Augmentative communication / Computer access / Other: \_\_\_\_\_

*If there was a written report, please attach, or arrange for us to receive, a copy.*

**PERTINENT BACKGROUND INFORMATION**

**Diagnosis:** \_\_\_\_\_ **How long has s/he had this diagnosis?** \_\_\_\_\_

If s/he take **medication**, what is it for? \_\_\_\_\_

Describe any **safety** issues we should know about (e.g., ventilator, seizures, etc.) \_\_\_\_\_

Any **vision** problems? (describe): \_\_\_\_\_ **Glasses?** Yes / No

Any **hearing** problems? (describe): \_\_\_\_\_ **Hearing aid?** Yes/No

**Walking:** Walks independently / Walks assisted (describe) \_\_\_\_\_ /Doesn't walk

**Wheelchair:** Power chair or scooter / Manual chair / None **Self propel?** Yes /No **Laptray?** Yes /No

If chair will be replaced soon, **When?** \_\_\_\_\_ **Why?** \_\_\_\_\_

**Hand function:** Right handed/Left handed **Weakness, tremor, paralysis, or other problems?**

(describe) \_\_\_\_\_

**Can s/he:** **Hold a pen?** Yes / No **Feed self?** Yes / No / Need help  
**Press buttons (as on a telephone)?** Yes /No **Comb own hair?** Yes / No / Need help

**Communication:** **Speech impairment?** (describe) \_\_\_\_\_

**Primary language?** \_\_\_\_\_ **Other language(s):** \_\_\_\_\_

**Cognition:** **Any problems with memory?:** Short term / Long term  
**Any trouble following directions?** Rarely or never / Occasionally / Often  
**Any trouble concentrating or sticking to a task?** Rarely or never / Occasionally / Often

**Education:** **Highest level completed:** \_\_\_\_\_ **In school now or soon?** Yes / No  
**Trouble: Reading?** Yes /No **Doing basic arithmetic?** Yes / No  
**Learning disability?** Yes /No **Describe** \_\_\_\_\_

**Does s/he have a personal care attendant?** Yes /No **If so, how often?** \_\_\_\_\_

**When was the last time the consumer received any:**

- Occupational therapy** Never / Over a year ago / Less than a year ago / Receiving now or soon
- Speech/language therapy** Never / Over a year ago / Less than a year ago / Receiving now or soon
- Physical therapy** Never / Over a year ago / Less than a year ago / Receiving now or soon
- Vocational eval./training** Never / Over a year ago / Less than a year ago / Receiving now or soon
- Other rehab/therapy** Never / Over a year ago / Less than a year ago / Receiving now or soon

**describe:** \_\_\_\_\_

**COMPUTER ACCESS SCREENING INFORMATION**  
**To be completed ONLY for consumer needing COMPUTER ACCESS services**  
(see next page for Augmentative Communication section)

What will the consumer use a computer for?

Word processing / Graphics / Internet / Education / Other (specify): \_\_\_\_\_

Does s/he own a computer now? If so, what type? \_\_\_\_\_

How much experience does s/he have with personal computer applications?

Word processing	Almost none / A little / Quite a bit / A lot
Computer graphics	Almost none / A little / Quite a bit / A lot
Internet	Almost none / A little / Quite a bit / A lot
Educational programs	Almost none / A little / Quite a bit / A lot
Games	Almost none / A little / Quite a bit / A lot
Other: _____	Almost none / A little / Quite a bit / A lot

What SPECIFIC difficulties is the consumer having (or is expected to have) with using a computer because of the disability? (For example: arm gets tired; can't read screen; hit 2 keys at once ; mouse moves when pressing button; etc.) Describe ALL difficulties:

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

Describe any special computer equipment or software s/he has used because of the disability (For example: special keyboard, left-handed mouse, typing stick, keyboard tray; talking word processor, etc.)

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

Does s/he have pain when using a computer? Don't know/No/Yes (where): \_\_\_\_\_

How long before pain starts? \_\_\_\_\_ How long before s/he stops due to pain? \_\_\_\_\_

Has s/he been treated for the pain? No / Yes What does the doctor say? \_\_\_\_\_

\_\_\_\_\_

Where will the consumer use the computer? (circle all that apply)

A) Home / Work / School / Other \_\_\_\_\_

B) Lying on bed, couch / Standing / Office chair / Kitchen-type chair / Easy chair, couch / Wheelchair

C) Computer will be on: A desk / A table / In lap / A computer workstation / On laptray

**AUGMENTATIVE COMMUNICATION SCREENING INFORMATION**  
**To be completed ONLY for consumer needing AUGMENTATIVE COMMUNICATION services**  
(see previous page for Computer Access section)

**Current methods of communication (circle all that apply):**

- Speech
- Yes-no responses
- Gestures, facial expressions
- Manual communication board
- Electronic communication device (name) \_\_\_\_\_
- Other: \_\_\_\_\_
- Sounds
- Sign language
- Writing
- Eye gaze

**Who can understand the consumer’s communication, and how well?**

- Strangers      Nearly always / Part of the time / Almost never / (not applicable)
- Teachers      Nearly always / Part of the time / Almost never / (not applicable)
- Peers, friends      Nearly always / Part of the time / Almost never / (not applicable)
- Parents      Nearly always / Part of the time / Almost never / (not applicable)
- Siblings      Nearly always / Part of the time / Almost never / (not applicable)
- Other      Nearly always / Part of the time / Almost never / (not applicable)

**What does the consumer do when s/he is not understood (circle all that apply)?**

- Keep trying to communicate the same message
- Get angry / become distressed or tearful
- Stop trying to communicate
- Change the message to make self understood
- Get person who understands him/her to translate
- Other: \_\_\_\_\_

**Does the communication problem affect the consumer’s: Social life? / Work or school life? / Family life?**

**Describe effects:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**If the consumer has an electronic communication device:**

**Does s/he use it? Yes /No If not, why not? What problems (if any) is s/he having with it?**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## PHOTO RELEASE

This release allows Abilities! to take your photograph or make videotapes of you during your participation in evaluation, training or other activities of the Nathaniel H. Kornreich Technology Center, for the following purposes:

- Yes  No For use in educational publications or presentations by the Kornreich Technology Center concerning assistive technology for persons with disabilities, or for publication, display, or media coverage to assist Abilities! to promote the abilities and potential of persons with disabilities
- Yes  No For printing, publication, display and/or media coverage to assist Abilities! to promote its activities or raise funds to support its activities toward the benefit of persons with disabilities

Your decision to agree or decline will in no way affect the services you receive at the Kornreich Technology Center or Abilities! You will never be photographed or videotaped without specific notification at the time. If you change your mind at any such time, staff will return this form to you to revise or destroy at your request. Photos or videos already taken may be withdrawn only prior to publication or release.

Additional comments or conditions: \_\_\_\_\_

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\_\_\_\_\_  
Consumer's signature

\_\_\_\_\_  
Consumer's name (print)

\_\_\_\_\_  
Parent's or guardian's signature

\_\_\_\_\_  
Name (print)

\_\_\_\_\_  
Relationship to  
consumer

## **Fees for Services to Individuals**

Most services provided by the Kornreich Technology Center (KTC) to individual consumers are billed at an hourly rate. These fees are summarized in our *Authorization of Service and Payment Agreement* form, and are detailed below.

### **Evaluation** (\$175.00/hour)

Assistive Technology (AT) evaluation is a complex process that varies greatly in length and complexity. In depth assessment of abilities, followed by hands-on trials of assistive technology products is the core of evaluation. Sessions usually last up to two hours each; multiple sessions are scheduled as needed to complete the evaluation.

### **Written justification option** (\$300.00 ea.)

AT evaluation (see above) includes written recommendations for: (A) AT products, including prices, and sources, (B) implementation ideas/techniques, (C) training for the consumer and others. At times, such as when third-party payment is being sought, a report detailing the process of the evaluation, other products considered, and specific justification for each item recommended is desired by the referrer. Preparation of that report is billed at a flat rate. The report must be requested within one month of receiving the recommendations.

### **Post-evaluation meeting option** (\$90.00/hour)

When a consumer, referring agency, family member, etc., asks to meet with a Kornreich Center staff member (in person or by telephone) to explain the recommendations in detail, attendance is billed at an hourly rate, plus travel time. The meeting must be requested within one month of receiving the recommendations (if longer, additional time will be billed so evaluator can review the case before the meeting). Meeting may be recorded by the requester for future reference.

### **Consumer training** (\$175.00/hour)

Consumers receiving AT systems, and/or their support staff, may require training before they can use the systems effectively. When the need for training is anticipated, Kornreich Technology Center makes training recommendations at the same time as product recommendations. Recommended hours are estimates, as trainees vary widely in their rates of learning. Training recommended by the Kornreich Center need not be performed here; each case is different.

### **Setup/modification; Technical support** (\$150.00/hour)

After assistive technology products have been procured for a consumer, setup, installation, adaptation, or other means of customizing the product for that individual's use are sometimes required. These functions may be performed by the consumer/family, by someone on the consumer's support team, by the vendor who sold the product, or by the product's manufacturer. If such services are provided by the KTC, they are billed at an hourly rate.

Technical support (troubleshooting, answering questions, etc.) is usually provided by the manufacturer or vendor of the product, by telephone, via the Internet, or in person. At our discretion, the KTC sometimes provides support as well. Questions requiring brief, unresearched responses are usually answered without charge. More extensive technical support is billed at an hourly rate.

### **Ancillary services** (\$100.00/hour)

Services that place lower demands on staff time or expertise are billed at a lower rate. Such ancillary services include: independent research into assistive technology options, testing or

configuration of products in preparation for an evaluation session, routine production of materials in alternative formats, etc.

**Travel time** (\$60.00/hour)

When Kornreich Center staff must travel to do an on-site evaluation, provide training or technical support, or attend a meeting, travel time is billed. This charge covers the *time* of the professional involved. Reasonable time deductions are made for time spent in traffic, or other travel delays.

**Screening** (\$175.00)

Occasionally, it is advisable to see a consumer for a preliminary screening *before* deciding whether an assistive technology (AT) evaluation is appropriate. This may occur if there is doubt about candidacy for AT or about goals. Screening, consisting of in-depth interview plus observation designed to clarify the nature of the consumer's problem, is a one-time event, billed at a flat rate for up to one hour of service.

**Equipment rental**

If a consumer's device is out for repair, or s/he is waiting for delivery of a new device, the KTC can provide short-term rentals (up to four months) for some communication devices and other assistive technology. Such rentals apply to devices previously recommended by a qualified assistive technology service provider, and is *limited by the availability of hardware owned by the KTC*. Software is not available for rental. Rental fee is determined by several factors; please contact the Kornreich Technology Center for details.

**Consultation services**

The Kornreich Technology Center provides consultation and training services on a contractual basis to schools, school districts, agencies, employers, etc. Each contract is unique, and rates are determined for individual contracts..

**Services not billed** include (but are not limited to):

Administrative paperwork and billing. Telephone and e-mail contacts for scheduling and other routine purposes. Responding to brief technical questions requiring no research. Ordering, maintenance and repair of KTC equipment and supplies used during services.