The AT Messenger…bringing technology to you

Delaware Assistive Technology Initiative (DATI), Volume 10, No. 4, Winter 2003

Report on Unmet AT Needs Headed for Dover

In the waning hours of the Delaware General Assembly's last session, the Delaware Assistive Technology Policy Committee was established. The Committee's charge was to examine and report on the need for personal mobility and vehicular transportation technologies in Delaware. Because assistive technology use is generally not limited to one life domain, the Committee has been looking broadly at the unmet needs for assistive technologies supporting access, communication, self-care, seeing, hearing, recreation, community participation, learning, and working. Public hearings held in early January gave people with disabilities in Delaware a chance to testify about the AT they need and why they haven't been able to get it. The Committee's report, due to the legislature in mid-January, will:

- describe the benefits of home modifications, vehicle modifications, and AT
- document the unmet need for home and vehicle modifications and AT in Delaware
- describe the barriers to accessing needed modifications and AT
- offer recommendations for ways that Delaware can improve access to modifications and AT for those who need them.

We are hopeful that the General Assembly will enact legislation that improves AT access. We are also hopeful that it will support the establishment of a low-interest loan program that Delawareans can access to get the home and vehicle modifications and the AT that they need. For more information, contact Beth Mineo Mollica at the DATI Central Site.

Meet DATI Newest AT Specialist

Hello! My name is Marvin Williams and I am the new Assistive Technology Specialist for the Kent County Assistive Technology Resource Center. I have recently moved to Delaware with my wife, April, and our five year old son, Gabriel. I come to you from Tampa, Florida, where I worked for five years as a Rehabilitation Engineer at the Shriners Hospital for Children. Before that, I worked as an adaptive equipment technician at the Woodward State Hospital School, an intermediate care facility for people with mental retardation, in Woodward, Iowa. My education includes a Bachelor of Science in Mechanical Engineering from Santa Clara University in California and a Master of Science in Biomedical Engineering from Iowa State University. From my time at Shriners, I have extensive experience in providing commercially available AT products; my time at Woodward added to my skills in the design and fabrication of custom equipment and adaptive equipment. If there is some way that I can help you, please let me know. My door is always open. I look forward to meeting many of you and to serving the people of Kent County as a member of the DATI team.

Medicaid Home and Community Based Waiver Programs: Supporting Individuals with Disabilities in the Most Integrated Setting Possible

Eliza Patten, Disabilities Law Program

The major source of public funding for long-term services and supports for persons with disabilities nationwide is Medicaid. The percentage of Medicaid spending on services and supports provided in the home or a community setting has grown exponentially. These services may be offered either through a state's "regular" Medicaid program or through a home and community-based services (HCBS) waiver program. This article will outline the use of Medicaid HCBS waivers by states to supplement and expand the services available to persons with disabilities in their homes and communities.

In 1981, Congress authorized the waiver of certain federal requirements to enable states to provide home and community services (other than room and board) to individuals who would

otherwise require institutional care reimbursable by Medicaid. The waivers are authorized by section 1915(c) of the Social Security Act and are sometimes referred to as 1915(c) waivers. For purposes of this article they will be referred to as HCBS waivers. Services extend beyond those covered by the state Medicaid plan. In addition, waiver programs may allow states to provide services not viewed as strictly medical (e.g., homemaker or chore services, respite care, wheelchair lifts, and home modifications) provided the services are related to the need for long-term supports and services in the community.

A state may offer several HCBS waiver programs at once, each offering a distinct package of supports and services to a different group of individuals. Waivers provide an invaluable opportunity for states to customize benefit packages to meet the needs of their constituencies with disabilities. A state can qualify a wider range of individuals for Medicaid using an HCBS waiver program than it can under its state plan. Equally important is the ability waivers give states to empower individuals with disabilities to pursue the common goal of enhancing personal choice and freedom of control over daily activities in the most integrated setting possible, as specified in the Olmstead decision.#

When Medicaid was first enacted, its main purpose was to cover primary and acute health care services. Since 1970, Medicaid has evolved into a program that allows states considerable flexibility to cover virtually all long term care services that enable persons with disabilities to live independently in home and community settings. The services that can be offered without a waiver are called Medicaid state plan services. Some of these (e.g., home health care) are mandatory services. Other services can be provided at state option. When a state covers a service under its Medicaid plan, it must specify any limitations as to (1) amount (how often a person may receive a service); (2) duration (for how long); and (3) scope (the exact nature of what is provided). Services must be sufficient to meet the needs of most people most of the time and may not undermine a person's receipt of necessary assistance.

Optional state plan services, once a state elects to offer them, must also be made available to all individuals who require the service, within the limitations the state may have established. Generally, the optional services offered under the state plan must be

available statewide (the “statewideness” requirement) and they must be available on a comparable basis to all Medicaid recipients who require the service (that is, the state may not offer them only to persons who have a particular condition or offer them in different forms to different groups.) This latter condition is referred to as the “comparability” requirement. A state has the option of covering four main home and community based services, including (1) personal care; (2) targeted case management; (3) clinic; and (4) rehabilitative services. Targeted case management services are exempt from the comparability and statewideness requirements; however, once a state has established its target population, the services must be furnished to all eligible individuals. In contrast to waiver programs, a state may not limit the number of individuals eligible to receive these services.

Waiver programs are exceptional in that they are exempt from the statewideness and comparability requirements. This enables states to target services to distinct groups of Medicaid beneficiaries. Therefore, supporting home and community services through waivers can be considerably less expensive for states than electing to adopt an “optional” service in the state plan. In addition, there are some HCB services a state may not offer under its Medicaid state plan—but could offer through a waiver—either because they have not been specified in the authorizing legislation and regulations (e.g., respite care) or because they may be provided under the state plan only as a component of institutional services (e.g., habilitation).

To be eligible for services, individuals must first meet a waiver’s targeting criteria, such as age and diagnosis or condition. A state may have a number of different waivers targeting different groups. Individuals who meet target criteria must then meet service criteria; that is, they must meet Medicaid’s “level of care” criteria for determining eligibility for institutional care. This decision is made through a formal assessment process at the time of application for service. Because these criteria are essential to preserving the primary purpose of the waivers–to offer an alternative to institutionalization–the criteria may not be waived or amended except by Congressional action.

It is worth noting that stringent level of care criteria limit the assistance that states can provide to those who need only a small

amount of help to remain in the community, and thereby may unintentionally increase the costs of institutionalization. The incentive for setting stringent criteria is a fear that more flexible or functional criteria will “open the floodgates” to persons demanding institutional care. In reality, the overwhelming majority of persons with long-term care needs would prefer to be served in the community and will not seek an institutional placement. The availability of HCB services in fact reduces the demand for institutional services.

Service criteria, on the other hand, should be developed only after a thorough assessment of the full constellation of services and supports a state provides, either through its Medicaid plan or through other state and local resources. The aim of the criteria should be to ensure that all individuals with long-term care service needs are able to obtain the particular service appropriate to their need. Federal policy prohibits waivers from covering precisely the same services as are already covered under the state plan; however, if a state offers a service under its Medicaid plan with restrictions, the waiver may offer what are termed “extended” state plan services to provide more complete coverage.

To assist states in submitting requests to begin waiver programs, the Centers for Medicaid and Medicare Services (CMS) published a standard HCBS waiver application format, including CMS-suggested definitions of a wide range of services states may use to specify what their waiver program will cover. These include: case management/care coordination services; personal care and assistance services; services usually furnished in settings other than a person’s home; specialized, disability-related services; services for individuals with serious persistent mental illness; health-related services; assistive devices, adaptive aids, and equipment, including home and vehicle modifications; and family training and respite care. Each of these categories will be discussed briefly below; included are some services that are not listed in the CMS definitions but that have been approved for inclusion in waiver programs.

1. Case management/care coordination services.

Case management/care coordination services are designed to help individuals who need services and supports from several sources. They may include assessment, service/support planning,

arranging for services, coordinating service providers, monitoring and overseeing provision of HCBS waiver and other services furnished to an individual, and helping individuals gain access to non-Medicaid services.

2. Personal care and assistance services.

Personal care and assistance services can include help with Activities of Daily Living (ADLs) such as eating, bathing, dressing, toileting, and Instrumental Activities of Daily Living (IADLs) such as light housework, laundry, transportation, and money management. This provision can support a paid worker—such as a personal care attendant (with attention to health care needs), home health aide, homemaker, or chore services (for heavy household work)—and may be provided in the home, community or a community living situation. Homemaker services, in particular, may not be covered under a state's Medicaid plan on a stand-alone basis; rather, they are covered only as an adjunct to personal care services. In addition, cost concerns often lead states to restrict the amount of home health aide services provided through the mandatory home health benefit. In both these cases, waivers present the potential to provide a greater amount of services.

3. Services necessary to support a person living in arrangements other than their home.

Services necessary to support people in living arrangements other than their home, excepting room and board, are typically covered by waiver programs. Residential habilitation services–geared to helping individuals acquire, retain, and improve ADL-related skills necessary for community life–combine habilitation, personal care and supervision into a single service. They are commonly used in waiver programs for persons with mental retardation and may include transportation services as needed. In contrast to habilitation services under the state Medicaid plan, which may only be furnished to residents of Intermediate Care Facilities for the Mentally Retarded (ICFs/MR), waiver-supported habilitation services can be provided to people living on their own.

Adult foster care is another service necessary to support people living outside their home. Adult foster care combines personal care

and services, homemaker, chore, attendant care, companion services and medication oversight provided in a private home by a principal care provider who lives in the home. Licensing requirements may apply to non-relative caregivers. Similarly, assisted care services encompass the same categories of services and supports but are provided in a community care facility to those living in the facility.

4. Specialty services.

The fourth general category are specialty services, which are disability-specific services generally provided away from the individual's living arrangement. This is potentially a very broad category. Day habilitation is a term used to refer to assistance with acquisition, retention and improvement in self-help, socialization, and adaptive skills to enable individuals to attain or maintain their maximum functional level. This is a very common waiver program service for individuals with mental retardation. Transportation may be included in the scope of day habilitation services. Extended habilitation services go further and include pre-vocational services (aimed at preparing an individual for paid or unpaid employment), educational services (special education and related services beyond those available under the Individuals with Disabilities Education Act or Section 504 of the Rehabilitation Act), and supported employment services (when needed to sustain paid work including supervision and training). Extended habilitation services may not be provided under the state Medicaid plan except to individuals residing in ICFs/MR.

There are three specialized services that a state may cover under its state Medicaid plan for individuals with serious, persistent mental illness: (1) clinic services; (2) day treatment or other partial hospitalization services; and (3) psychiatric rehabilitation services. These services also may be covered by HCBS waiver programs serving other target populations, including individuals with dual diagnoses. The advantage of covering these services under an HCBS waiver program is that they may be furnished in locations other than clinic sites.

5. Health-related services.

The category of health-related services includes skilled nursing, private duty nursing, and extended state plan services. Examples include assistance with such activities as tube feeding, catheterization, or range of motion exercises. Extended state plan services are exactly that: the same health and other services available through the state plan but without the limitations on amount, duration and scope specified in the plan. The waiver program will pick up once the state plan limitations have been reached.

6. Assistive devices, adaptive aids, and equipment; home and vehicle modifications.

This category includes a wide range of environmental accessibility adaptations—all physical adaptations to the home that either (a) are necessary to ensure the health, welfare, and safety of all individuals, or (b) enable them to function more independently in the home and without which they would require institutionalization. These types of adaptations can almost never be covered under the state Medicaid plan, making them a key consideration for waiver inclusion. Pennsylvania, for example, has an HCBS waiver which includes as household adaptations the following: ramps; handrails; grab bars; smoke/fire alarms for persons with sensory impairments; outdoors railings; widened doorways, landings, and hallways; kitchen, bathroom and bedroom modifications; workroom modifications; and stair glide and elevating systems. Waivers are also available for vehicular modifications, and Pennsylvania's waiver program includes vehicular lifts, interior alterations, and other customized devices necessary for the individual to be transported safely in the environment.

Other assistive devices or adaptive aids and equipment may include specialized medical equipment and supplies that increase an individual's ability to perform ADLs, or to perceive, control, or communicate with their environment. Examples may include medication administration boxes with timed alarms, electronic communication devices, computers or computer adaptations, and other assistive technology services which enable individuals with severe disabilities to use technology to perform activities on their own. These types of services reduce the need for workers to provide the service and increase the individual's independence and self-sufficiency. This also includes life support equipment and Personal

Emergency Response Systems (PERS) that enable individuals at high risk of institutionalization who live alone or are alone for long period of time—and would otherwise need extensive routine supervision—to secure help in an emergency. Finally, transportation is a service enabling waiver participants to gain access to waiver and other community services.

7. Family Training and Support.

Family training and respite care are services provided to family members or other caregivers to help relieve them of caregiving responsibilities. Family training may include instruction about treatment regimens and use of equipment specified in an individual's plan of care. Respite care, by contrast, is short term care provided in the absence of or as relief for those persons normally providing the care. Respite care is not available under the state's Medicaid plan.

8. Other approved long-term services and supports approved for waiver programs.

CMS requires a precise definition of what will be furnished to waiver participants; therefore, it is best to begin by developing a clear understanding of what the state intends its waiver program to accomplish, including the types of services and supports to be delivered (how, where, and by whom). Then the state should look at the CMS-proposed service definitions and make a determination whether the predefined service fits. If it does, it is always easier to use the CMS-predefined coverage. If it doesn't, however, it is important to remember that the CMS list is only intended as guidance and should not be construed as limiting.

"Off-list" services that have been approved for HCBS waivers include crisis intervention services that stabilize persons in their current living arrangement. In California, for example, a mobile crisis intervention model is used to provide immediate, time-limited, therapeutic intervention on a 24-hour emergency basis to an individual exhibiting acute personal, social, and/or behavioral problems that, if not addressed, would threaten the health or safety of the individual and result in the individual being removed from the current living arrangement.

Other examples of CMS-approved waiver services include: behavioral services; community participation supports to encourage community integration and discourage reliance on site-based services; housing coordination for persons who are homeless or at risk of becoming homeless; supported living services that bring needed supports to individuals in their own homes; and consumer training and education aimed explicitly at teaching individuals skills they need to manage their own supports and advocate on their own behalf.

It is up to individuals with disabilities and their advocates to encourage states to create multiple, innovative HCBS waivers to enhance existing resources and ensure an integrated service delivery system. Waivers are "works in progress." History has revealed that the states operating numerous waivers are constantly re-shaping and re-defining their programs as they learn more about how best to serve their communities. It is clear that HCBS waiver programs are an invaluable tool for increasing the depth and breadth of service options to support individuals with disabilities in the most community-centered, integrated environments possible. People with disabilities are deserving of nothing less.

Zen and the Art of Successful AT Transitions

Marvin Williams, AT Specialist, Kent County ATRC

It's Susie's first day at the Xavier School. All of Susie's teachers and therapists, as well as Susie's parents, have been working hard for years to get her ready for this day. Her power wheelchair is charged, her Portable Impact Tablet is charged, and the back-up power converter allowing the tablet to run on the power wheelchair batteries is working and connected. Her backpack with medications, ADL equipment, and personal supplies is mounted to the back of the chair. Susie wished that Melanie, her assistant for the past five years, was coming with her, but, unfortunately, that was not possible. Still, Susie was excited about her new school and about making new friends.

Susie's parents arrived at the principal's office 30 minutes after they had been called to take Susie home. Their daughter was in the nurse's office crying, obviously very upset, yet she did not respond to

questions. All she could say was “what.” This was odd because she was a pro with her tablet communication device. Her mother noticed that the symbol library on the tablet was gone. Instead, a QWERTY keyboard with a word prediction window was in its place. The low battery light flashed just before the device shut down. Her father reconnected the back-up power converter, which had been unplugged. With power restored, Susie’s father loaded her custom communication symbol set. Her mom filled the portable water pack at the sink and clipped Susie’s sip straw to her shirt so she could easily reach the straw for a much needed drink. After two button pushes, the device’s synthesized voice began to communicate Susie’s tale: “I had a bad day…”

I’m sure that we have all heard similar stories of problematic transitions from one school to another. I’m sure that we’ve even heard of challenging transitions within the same facility due to internal changes. The simple fact is that changes in AT require a transfer of information from one group of service providers and support staff to another. One of the things that makes equipment transitions so important is that there are so many of them. In schools, they occur when a student gets a new teacher or a new paraprofessional. They can also occur when a student is transitioned into a different educational environment, at the end of the school year, or if the student changes schools for any reason. In an institutional setting, they can occur when an individual changes support staff or changes facilities and/or programs. In any case, when new people are involved with an individual, those new people are likely to need instruction on the particulars of an individual’s AT use.

As transitions are inevitable, we can and should prepare for them as best we can. Without such planning, we jeopardize the efficiency of the transition process. The equipment may not be complete or may not be working properly. Problems with equipment ownership may arise if an item’s history has not been documented. The new staff may not know how to operate the equipment or how the particular individual uses the equipment. All of these problems—or even one of them—is enough to cause big headaches for everyone. The key to preventing these problems, or at least minimizing their destructive effects, is the successful transmission of AT information between service teams.

In the beginning. . .

So how can AT be effectively and efficiently transitioned from one service team to another? As with most things, preparation is the key. AT should be an explicit element of transition planning. A transition plan should provide adequate information about the AT and its use. It should also identify those who will facilitate transition of the equipment from one setting/situation to another. The team might include teachers, therapists, paraprofessionals, resource specialists, AT specialists, parents, administrators, and the AT user. Although this list is by no means comprehensive, it suggests several people who are likely to play a part in AT transitions.

The thing to keep in mind when forming the transition team is that each member needs to have a clearly defined role that is understood and accepted by all members. The team should also have a leader or coordinator who will keep the process moving along on schedule and according to the established plan. The leader should also monitor the transition to determine whether the supports following the transition are adequate to meet the AT user's needs.

Follow the yellow brick road!

The timeline for the transfer of equipment should include all appropriate milestones and deadlines. This way, team members will have a clear sense of how their responsibilities contribute to the overall objectives. Here are some points to keep in mind when developing a timeline:

- Be sure to describe all steps in the transition of equipment from one environment to another. This provides a "heads up" for all involved, and enables revision to the plan in advance if necessary.

- Give plenty of time for successful information gathering. Most service providers have a multitude of responsibilities, and cannot ignore other duties just because they receive a last-minute request. With adequate advance notice, team members will be able to compile information enabling the new team to become familiar with the AT and the user's needs.

- Create milestones. Schedule meetings around the milestones to make sure that everything is going as planned. If someone is having a problem gathering information or completing some other task, the group can troubleshoot or revise the plan. Not all meetings need to be conducted face-to-face; email can facilitate effective and efficient “virtual” meetings. The important thing is to keep the team informed.

By following a transition plan complete with timelines, even the most complex equipment transfers can be accomplished with minimal disruption for the AT user.

It’s not who you know, but what you know

Because a successful transition depends on accurate transfer of information, the team will need to generate documentation about each device if no previous record exists. Important information might include an item’s purchase history, repair history, and cleaning and maintenance schedule. This will tell the new team who purchased and owns the device as well as who is responsible for its maintenance. Maintenance information should also specify any special procedures that must be followed if the device requires service. For example, does the device need to be returned to the manufacturer for service, or can it go to a local service center? Are there special shipping instructions or a certain department within the manufacturing company that must be consulted? Is there an associated cost for cleaning and repairs? If so, who pays, and what is the payment procedure?

In addition, the team needs to learn the item’s usage history. This describes who initiated the use of the equipment, when and how it is used, and who is trained to use it. It is also important to know if the item is part of an individual’s IEP or treatment plan, as this will provide additional insight into how the equipment is intended to support the user. If the team finds that the item is no longer accomplishing its intended purpose, the treatment plan will need to be updated to reflect any change in implementation.

If an individual’s AT includes software with customized user settings, those need to be documented and sent with the user. Otherwise, the work that went into tailoring a piece of software for a

specific user will be lost, and someone will have to undertake the customization process all over again.

An ounce of prevention

A successful equipment transfer is possible with thorough planning and preparation. While it takes work to gather the necessary information, advanced planning saves time and aggravation in the long run. Perhaps the best way to keep transition preparation from becoming overwhelming is to maintain up-to-date documentation on equipment history and use. As a consumer's equipment is serviced or changed, make sure that the circumstances are documented. Transitions are inevitable; the goal should be to make the transfer of equipment as efficient for all members of the team as possible.

Augmentative Communication Training Planned for April

duPont Hospital for Children Workshop

Dick Lytton, Director of Clinical AT Services at the duPont Hospital for Children, will present a full-day workshop on April 3, 2003 titled Implementing Assistive Technology and Augmentative Communication in Schools and Homes. The workshop will present techniques and strategies that help children and youth with disabilities to achieve functional participation and independence using their technology tools for:

- Early interaction and preschool learning
- Behavior organization and expressive communication
- Classroom participation, academic success, and homework.

Workshop sessions will include emphases on language, learning, and academic goal setting; facilitation and support strategies; and approaches that integrate AT in classroom and home-based activities. For further information, contact Lauren Winnington at

the duPont Hospital for Children at 302-651-5595 (voice), 302-651-5612 (fax), or lwinning@nemours.org (email).

Communication Aid Manufacturers Association (CAMA) Workshop

CAMA is a not-for-profit organization of the world's leading manufacturers of AAC software and hardware technology, and is a recognized leader in helping professionals and consumers with a wide range of experience maintain their proficiency and enhance their skills and knowledge of AAC. The CAMA AAC Workshop is a unique "portable" trade show that is affordable and convenient—close to home and only one day. Representatives from as many as 12 different AAC companies conduct the interactive and hands-on presentations that help attendees understand the diversity of AAC technology, distinguish among the type of products offered, and understand their functional applications in a variety of communication situations.

This year's workshop will be held on April 4 in the greater Wilmington area. The fee of $65 (pre-registration) or $90 (on-site registration) includes workshop materials, all sessions, continental breakfast, and lunch. A discounted pre-registration rate of $35 is available to students and consumers, and CAMA offers a group discount as well. ASHA CEUs are available at no additional charge. For more information, or to register, visit CAMA's website at www.aacproducts.org or call CAMA at 1-800-441-CAMA (2262).

New Program Promotes Access to Distance Learning

An increasing number of institutions of higher education are turning to distance learning to serve their students, according to the National Center for Education Statistics. However, most distance learning courses are limited in accessibility and pose problems for full participation of students and instructors with disabilities. This is soon going to change.

The Southeast Disability and Business Technical Assistance Center (DBTAC), a unit of the Center for Assistive Technology and Environmental Access (CATEA) within the College of Architecture,

recently received a grant from the Office of Post Secondary Education at the U.S. Department of Education for a demonstration project to enhance access for students with disabilities to distance learning courses.

"The exciting thing about this project is that we are not just going to 'make over' a few distance learning courses, our goal is to provide training and technical assistance that can improve distance education practices nationwide," says Robert Todd, Project Director for the grant.

Todd and his team will collaborate with two other centers at Georgia Tech: the Center for Distance Learning and the Center for Enhancement of Teaching and Learning. Georgia Tech faculty will receive training on accessible course design, and these core faculty members will be funded to make existing and new distance education programs accessible to students with disabilities. Project staff will also work with the Georgia Tech Office for Students with Disabilities to raise awareness about the need for accessible distance education on the Georgia Tech Campus for both faculty and students and to evaluate the accessibility of the courses identified.

"While Georgia Tech will be used as an example of successful practices in accessible distance education, this information will be disseminated to other educational entities nationwide, giving them the tools they need to create their own accessible distance education courses," says Todd.

The grant will also help fund a public-private partnership between CATEA and IDET Communications, Inc., a private company based in Atlanta, to develop a fully accessible ten-module online training course designed to increase awareness about disability and accessibility issues in distance learning.

Additionally, the project will work with Multimedia Educational Resource for Learning and Online Teaching (MERLOT) to develop voluntary standards and procedures for evaluating the accessibility of online courses and to include that information in the MERLOT database of online courses. MERLOT is a free and open resource designed primarily for faculty and students in higher education.

For more information on this project, contact Robert Todd at robert.todd@arch.gatech.edu.

Essays Wanted

Guidelines for a Different Journey: Personal Stories for Parents by Adults with Disabilities is a new book that Stan Klein and John Kemp are co-editing. For this book, adults who have grown up with disabilities and/or health care needs are invited to write short essays for parents of children with disabilities and/or health care needs. In their essays, authors are asked to write an essay that they wish their own parents had read or been told while they were growing up.

Here are specific guidelines for essays:

1. Please write an essay of about 1500 words, or less. Add a biography of about 150 words, or less, that would follow the essay in the book. At the end of the essay, please write your mailing address, telephone number, fax number, and Email address.

2. Please submit your essay as an attachment in Microsoft Word to an Email or paste your essay into the body of your Email. Send Email to: stan@disabilitiesbooks.com

3. If you submit your essay by regular mail, please double space the text. If at all possible, please also submit the essay on a disk as well. Please label each page of your printed essay and the disk with your name and address. Please send the printed copy and disk to: Stanley D. Klein, Ph.D., DisABILITIESBOOKS, Inc., P.O. Box 470715, Brookline, MA 02447-0715.

4. Deadline: All essays are to be received by February 15, 2003.

Authors of essays accepted for inclusion in the book will receive $125 for the right to include their essay.

New Address for CAST

CAST has moved. Find them now at:

40 Harvard Mills Square, Suite 3

Wakefield, MA 01880-3233

Phone: 781-245-2212

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PreK AAC Research Participants Needed

A doctoral student at Michigan State University is studying family fact ors that may affect successful agumentative and alternative communication (AAC) system use. Eligible participants are parents of pre-kindergarten children (ages 1-6 years) who have used their current AAC system for 6-12 months.

Parents will be asked to complete (a) a case history form which describes the AAC system and demographic information such as age, occupation, AAC user's diagnosis, (b) a rating system on how AAC has affected the family's life, and (c) the AAC Family-Paradigm Assessment Scale on how the family accomplishes daily activities. These scales can be completed either in your home by paper and pencil and mailed back to the researchers or through a secure Website. Participants will be paid $15 for approximately 60-90 minutes of their time.

For more information, contact Mary Jo Cooley Hidecker by email hidecke1@msu.edu, by phone 517-355-9721, or by mail to the Department of Audiology & Speech Sciences, Michigan State University, 378 Communication Arts & Sciences, East Lansing, MI 48824.

Tech Tidbits

PAC Mate

Freedom Scientific's newest notetaker device for people with visual impairments includes access to Microsoft Outlook and all Pocket PC applications. The PAC Mate, developed in conjunction with Microsoft, is a handheld Windows CE computer that uses JAWS screen reading technology. Although the product is billed as an accessible PDA (personal data assistant), it is a bit larger and more expensive that most Pocket PC devices. It includes a full-sized keyboard (choice of QWERTY or 8-dot braille) and weighs 1.5 pounds. Wireless capabilities can be added to the device via an expansion slot, and allows users to access the Internet, e-mail and GPS information with text to speech output. The PAC Mate will be available at the end of 2002 for about $2,595.

Contact:

Freedom Scientific

Phone: 800-444-4443 or 727-803-8000

http://www.freedomscientific.com

ErgoQuest Sit/Stand/Recline Workstations

ErgoQuest makes two models of workstations for computer users who need to work from a bed or a recliner in a supine position. The Model 300 has a cantilever design that holds up to a 17” monitor. The newer Model 500 straddles a twin-sized bed or recliner, and it can support heavier equipment and larger monitors. For either model, a monitor is fastened into a stand that tilts up to 60 degrees so that a person who is reclining can still see the screen. The workstations also have an adjustable keyboard tray that tilts up to 90 degrees to fit user needs. Motorized legs adjust the workstation height from 31 to 50 inches with the push of a button. This range in height adjustment allows users to work from a reclining, sitting, or standing position. The base price for the workstations is $2,995.

Contact:

ErgoQuest

Phone: 888-298-2898 or 616-990-1107

http://www.ergoquest.com

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