STATE OF NEW JERSEY
DEVELOPMENTAL DISABILITIES
SPEECH ASSESSMENT FORM (SPAF)

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Prepared by DD Planning Institute
New Jersey Institute of Technology

Prepared for State of New Jersey
Division of Developmental Disabilities

Consumer Name/
MIS Number

DD Center Name/
Cottage Name

Respondent Name/
Respondent ID Number

Date Completed ____ ____/ ____ ____/ ____ ____

PURPOSE

THIS ASSESSMENT COLLECTS FACTUAL INFORMATION ABOUT THE CONSUMER.

YOU CAN HELP BY ANSWERING SPECIFIC QUESTIONS ABOUT THIS INDIVIDUAL BECAUSE OF YOUR SPECIALIZED EXPERTISE AND TRAINING.

PLEASE COMPLETE THIS FORM ON THE BASIS OF YOUR OBSERVATION OF THE CONSUMER'S RECENT ACTUAL FUNCTIONING OR SITUATION, NOT ON WHAT YOU THINK MIGHT BE POSSIBLE IN THE FUTURE.

THANK YOU FOR YOUR ASSISTANCE.

1. Indicate whether the consumer **has done** each of the following **communication** tasks in the **last 4 weeks.**

A. Receptive Communication	NO	YES
a. Does (name) respond to his/her name when it is spoken or signed?	0	1
b. Does (name) understand the meaning of "yes" and "no"?"	0	1
c. Does (name) understand a one-step direction such as "Look at me"?	0	1
d. Does (name) understand a two-step directions such as "Turn your head and look at me"?	0	1
e. Does (name) understand a joke or story?	0	1

B. Expressive Communication	NO	YES
a. Uses **at least a few** simple words or signs to name specific objects like clothing or food?	0	1
b. Uses **many** simple words or signs to name specific objects like clothing or food?	0	1
c. Asks simple questions using words or signs?	0	1
d. Uses complete sentences when carrying on a conversation?	0	1
e. Tells a simple story such as about a television show?	0	1

Indicate whether the consumer **has done** each of the following **communication** tasks in the **last 4 weeks.**

C. Clarity of Verbal Speech	NO	YES
a. Says "yes" or "no" to a simple question?	0	1
b. Is his/her speech easily understood by strangers?	0	1
c. Is his/her speech easily understood by those who know him/her well?	0	1

2. Has the consumer received speech therapy in the **last 3 months** in any setting? 0 1

3. Regardless of where the consumer lives, what services might be necessary, if any, from a speech therapist (for either speech or dysphagia)?

1. None Needed
2. Needed on an Occasional Basis
3. Needed on a Frequent Basis

		NO	YES
4.	Has the consumer used a picture book or any other communication device at any time in the l**ast 3 months**? IF PRESCRIBED, BUT NOT USED BY CONSUMER IN THE LAST 3 MONTHS, ANSWER "NO."	0	1
5.	If a picture book or any other communication device were made available In his/her living environment, could the consumer benefit from using it?	0	1
6.	Has the consumer used a hearing aid at any time in the l**ast 3 months**? IF PRESCRIBED, BUT NOT USED BY CONSUMER IN THE LAST 3 MONTHS, ANSWER "NO."	0	1

7. Which answer best describes the consumer's **hearing** in the **last 4 weeks**?

IF USES HEARING AID, INDICATE STATUS OF HEARING WITH AID.

1. Normal range
2. Mild loss (often difficult to hear normal speech)
3. Moderate loss (have to turn up the TV or speak loudly to hear, deaf in one ear, etc.)
4. Severe loss (can hear only if someone is shouting)
5. Profound loss (can't hear)

8. Please provide information on any **swallowing conditions** that the consumer might have by completing the following 3 sections as described below.

A. Please circle whether or not the consumer has had the following **DIAGNOSED** condition or illness in the **last 2 years**.

B. **ONLY IF CONSUMER HAS CURRENT DIAGNOSIS,** circle whether consumer has seen or been reviewed by a doctor during the **last 3 months SPECIFICALLY** for this condition.

C. **ONLY IF CONSUMER HAS CURRENT DIAGNOSIS,** circle whether **THIS CONDITION** needs medical attention by a doctor **more often than once per year**.

	A. Has Condition?		IF HAS CONDITION(S), ANSWER BOTH			
			B. Seen or Reviewed by Doctor in the **Last 3 Months** for this Condition?		C. Condition Needs Medical Attention **More Than Yearly**?	
	NO	YES	NO	YES	NO	YES
Swallowing Conditions such as difficulty swallowing, gastric reflux, aspiration?	0	1	0	1	0	1

	NO	YES
9. Has the consumer had to be physically fed with utensils by staff or others in the **last 3 months** in any setting?	0	1

THIS QUESTION ASKS ABOUT PHSYCIAL ASSISTANCE WITH FEEDINGS USING ONE'S MOUTH.
IF NO FOOD IS GIVEN BY MOUTH, ANSWER "NO."

Thank you for your assistance!