

Evaluation Form

Fax Form To: 616 942-0024



Augmentative Communication Device (ACD) – Medicaid Only

Member

Name: _____ Parent Name (if applicable): _____

ID #: _____ DOB: _____

Address: _____

Referring Physician: _____ Specialty: _____

Medical Diagnosis: _____ Onset Date: _____

Speech Diagnosis: _____ Onset Date: _____

Evaluation Team - Indicate all who provided information for this evaluation and type of input

Name	Profession Speech/Lang	Credentials	License/Reg. #	<input type="checkbox"/> Report Only <input type="checkbox"/> On-site Participant
Name	Profession OT/PT	Credentials	License/Reg. #	<input type="checkbox"/> Report Only <input type="checkbox"/> On-site Participant
Name	Profession PSYCH	Credentials	License/Reg. #	<input type="checkbox"/> Report Only <input type="checkbox"/> On-site Participant
Name	Other	Credentials	License/Reg. #	<input type="checkbox"/> Report Only <input type="checkbox"/> On-site Participant

If any selected box on this form has an (*), a further explanation or description is required.

SECTION I: BACKGROUND INFORMATION

Provide pertinent history relative to diagnosis, prognosis and communication skills:

Current Hearing Status: Within normal limits with best correction? YES NO

Does hearing status influence the client's communication and/or the choice or use of a device? YES* NO
Explain*

Current Vision Status: Within normal limits with best correction? YES NO

Does vision status influence the client's communication and/or the choice or use of a device? YES* NO
Explain*

I-A. Current Educational Status

<input type="checkbox"/> Student: Indicate grade _____	Special Ed. Certification: <input type="checkbox"/> EMI <input type="checkbox"/> TMI <input type="checkbox"/> Speech & Language I <input type="checkbox"/> SMI <input type="checkbox"/> POHI <input type="checkbox"/> SXI <input type="checkbox"/> Other _____	Education Level completed to date:
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I-B. Current Vocational Status

Employed? YES Specify type: _____ Unemployed due to disability/medical status
 NO Other: Explain _____

Day Program? YES Specify type and level of participation: _____
 NO

I-C. Current Level of Therapy or Support Services

Type of Therapy/Service	Frequency (#/month)	Duration	Site (Outpatient, School, etc.)	Objectives

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I-D. Psychological Assessment and Status

Standardized Assessment Tool	Result/Developmental Level	Evaluator	Date of Test
Non-Standardized Testing			

SECTION II: SPEECH AND LANGUAGE STATUS Evaluated by Speech and Language Pathologist

Speech and Language Diagnosis _____

Briefly describe the beneficiary's speech and language therapy history

II-A. Communication Assessment: Include both expressive and receptive testing results

Standardized Assessment Tool	Result/Developmental Level	Evaluator	Date of Test
Non-Standardized Testing			
Oral Examination Test Instrument used:			
Prognosis for functional oral speech	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor		

II-B. Experience with Various Communication/Technology

Please include or attach client's current vocabulary sample with and without technology.

	No Experience	Unable	Past experience, not in current use	Current Use, limited function*	Current Use, Functional
Gestures:					
Explain: *					
Written Communication (describe)					
Explain: *					
Sign Language					
Explain: *					
Word/Picture/Symbol Board: (describe)					
# of words ____ # of pictures ____ # of symbols ____ # of phrases ____ # of sentences ____ Explain*					
Dedicated Communication System: (describe)					
# of words ____ # of pictures ____ # of symbols ____ # of phrases ____ # of sentences ____ Explain*					
Verbal Communication:					
# of words ____ # of phrases ____ # of sentences ____ Explain*					
Other: describe					
Explain*					

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SECTION III: MOTOR/POSTURAL/MOBILITY STATUS

This section must be evaluated by occupational or physical therapist if there is any limitation of motor, posture or mobility skills that affect the choice or use of an ACD.

Functional Ambulation/Mobility (please check)

- | | |
|---|--|
| <input type="checkbox"/> Independent ambulation
<input type="checkbox"/> Modified independent ambulation (devices, limited distance/control)
Specify: _____
<input type="checkbox"/> Dependent manual wheelchair user
<input type="checkbox"/> Manual wheelchair user, functionally independent | <input type="checkbox"/> Power wheelchair user: Specify type/site of activation device:

<input type="checkbox"/> Wheelchair currently being used needs to be modified/replaced in the near future. Specify anticipated changes in seating and timeline: |
|---|--|

Positioning ACD to be used in the following positions (check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Standing or walking
<input type="checkbox"/> Seated in wheelchair
<input type="checkbox"/> Seated in chairs other than wheelchair | <input type="checkbox"/> Posture in sitting unable to be fully corrected with devices or seating orthosis. Specify limitation: _____
<input type="checkbox"/> Lying prone or supine
<input type="checkbox"/> Other |
|--|--|

Is control of access affected by positioning? No Yes*
 Explain:*

Client's ability to directly access the requested ACD

- | | |
|--|--|
| <input type="checkbox"/> No limitation **
<input type="checkbox"/> Able, but unwanted activations/errors
<input type="checkbox"/> Able, but requires extra time/effort | <input type="checkbox"/> Able, but requires accommodation
<input type="checkbox"/> Unable |
|--|--|

**If "No Limit" to access, go to the Rationale for Prescribed Device section

Limited/impaired ability to access due to*

- | | |
|---|---|
| <input type="checkbox"/> Impaired vision
<input type="checkbox"/> Impaired strength or range
<input type="checkbox"/> Decreased sensation
*Describe type/severity: | <input type="checkbox"/> Abnormal or fluctuating muscle tone
<input type="checkbox"/> Other: Explain |
|---|---|

Access/Control type currently used

- | | |
|---|--|
| <input type="checkbox"/> Direct select without device modification
<input type="checkbox"/> *Check here if anticipated use for requested ACD is different.
Explain: | <input type="checkbox"/> Morse code
<input type="checkbox"/> Direct select with modifications. Specify: |
| <input type="checkbox"/> Multiple Switch: Specify type | Specify Sites: |
| <input type="checkbox"/> Single Switch: Specify type | Specify Sites: |

Yes*	No	
		Will ACD be integrated with other technology (w/c controls, ECUs, etc.)
		Will wheelchair or other mount be required?
		Does the client transfer into/out of his wheelchair independently?
Explain:*		

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Describe optimal access technique(s) including specific type and placement of switches and method by which optimal access technique was selected.

Rate of production with current communication system: (e.g., keystrokes/minute)

Rate of production with requested communication system: (e.g. keystrokes/minute)

Rate of accuracy (% incorrect activations)

SECTION IV: RATIONALE FOR PRESCRIBED DEVICE Identify all ACDs considered for the client. Choice of ACDs to consider should reflect a range from low to high tech, as appropriate. Recommended device should be the least costly alternative that meets the client's need for functional communication.

Device: Describe setup and any modifications or accommodations:	<input type="checkbox"/> Ruled out without trying due to: <input type="checkbox"/> Ruled out following trial due to: <input type="checkbox"/> Tried and considered appropriate
	Type of communication demonstrated: <input type="checkbox"/> Spontaneous <input type="checkbox"/> Response

of words ____ # of pictures ____ # of symbols ____ # of phrases ____ # of sentences ____

Device: Describe setup and any modifications or accommodations:	<input type="checkbox"/> Ruled out without trying due to: <input type="checkbox"/> Ruled out following trial due to: <input type="checkbox"/> Tried and considered appropriate
	Type of communication demonstrated: <input type="checkbox"/> Spontaneous <input type="checkbox"/> Response

of words ____ # of pictures ____ # of symbols ____ # of phrases ____ # of sentences ____

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	Type of communication demonstrated: <input type="checkbox"/> Spontaneous <input type="checkbox"/> Response

of words ____ # of pictures ____ # of symbols ____ # of phrases ____ # of sentences ____

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	Type of communication demonstrated: <input type="checkbox"/> Spontaneous <input type="checkbox"/> Response

of words ____ # of pictures ____ # of symbols ____ # of phrases ____ # of sentences ____

Client and caregiver's preference for device:

Rationale:

Type of current communication behaviors

Response to questions only Initiates occasionally Spontaneously initiates in a variety of settings

Type of communication behaviors demonstrated with recommended device

Response to questions only Initiates occasionally Spontaneously initiates in a variety of settings

Describe device requested, components, and vendor (include model and price)

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SECTION V: TREATMENT PLAN AND FOLLOW UP TRAINING IN USE OF THE DEVICE

Communication Goals (may attach additional)	Therapist/Facility/Agency	Timeline

Note: It is expected that the treating SLP will be involved with the development of this treatment plan. It is the evaluating SLP's responsibility to develop, in coordination with the client, caregivers, and treating SLP (e.g., school, day program, LTC) a basic vocabulary to be provided to the vendor (Provider type 87) for initial setup of the device.

Anticipated Frequency and Duration:

- Yes No* The patient/family/caregivers have been provided a copy of the above treatment plan, agree with the choice of the recommended device and to their participation in following and supporting the above treatment plan.

Explain*:

*****ALL FIELDS MUST BE COMPLETE AND LEGIBLE FOR PRIOR AUTHORIZATION REVIEW*****