Evaluation Form
Fax Form To: 616 942-0024
Augmentative Communication Device (ACD) – Medicaid Only

PriorityHealth

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. #	□ Report Only □ On-site Participant
Name	Profession OT/PT	Credentials	License/Reg. #	□ Report Only □ On-site Participant
Name	Profession PSYCH	Credentials	License/Reg. #	□ Report Only □ On-site Participant
Name	Other	Credentials	License/Reg. #	□ Report Only □ 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

□ Student: Indicate grade_____	Special Ed. Certification: □ EMI □ TMI □ Speech & Language I □ SMI □ POHI □ SXI □ Other_____	Education Level completed to date:

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	□ Good □ Fair □ 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 ____ Response communicator? □Yes □ No Explain* Initiates communication? □Yes □ No					
Dedicated Communication System: (describe)					
# of words ____ # of pictures____ # of symbols____ # of phrases ____ # of sentences ____ Response communicator? □Yes □ No Explain* Initiates communication? □Yes □ No					
Verbal Communication:					
# of words ____ # of phrases ____ # of sentences ____ Response communicator? □Yes □ No Explain* Initiates communication? □Yes □ No					
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)

□ Independent ambulation □ Modified independent ambulation (devices, limited distance/control) Specify: _____ □ Dependent manual wheelchair user □ Manual wheelchair user, functionally independent	□ Power wheelchair user: Specify type/site of activation device: □ 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)

□ Standing or walking □ Seated in wheelchair □ Seated in chairs other than wheelchair	□ Posture in sitting unable to be fully corrected with devices or seating orthosis. Specify limitation: _____ □ Lying prone or supine □ Other

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

Client's ability to directly access the requested ACD

□ No limitation ** □ Able, but unwanted activations/errors □ Able, but requires extra time/effort	□ Able, but requires accommodation □ Unable

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

Limited/impaired ability to access due to*

□ Impaired vision □ Impaired strength or range □ Decreased sensation	□ Abnormal or fluctuating muscle tone □ Other: Explain
*Describe type/severity:	

Access/Control type currently used

□ Direct select without device modification □ *Check here if anticipated use for requested ACD is different. Explain:*	□ Morse code □ Direct select with modifications. Specify:
□ Multiple Switch: Specify type	Specify Sites:
□ 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:	□ Ruled out without trying due to: □ Ruled out following trial due to: □ Tried and considered appropriate Type of communication demonstrated: □ Spontaneous □ Response
# of words ____ # of pictures____ # of symbols____ # of phrases ____ # of sentences ____	
Device: Describe setup and any modifications or accommodations:	□ Ruled out without trying due to: □ Ruled out following trial due to: □ Tried and considered appropriate Type of communication demonstrated: □ Spontaneous □ Response
# of words ____ # of pictures____ # of symbols____ # of phrases ____ # of sentences ____	
Device: Describe setup and any modifications or accommodations:	□ Ruled out without trying due to: □ Ruled out following trial due to: □ Tried and considered appropriate Type of communication demonstrated: □ Spontaneous □ Response
# of words ____ # of pictures____ # of symbols____ # of phrases ____ # of sentences ____	
Device: Describe setup and any modifications or accommodations:	□ Ruled out without trying due to: □ Ruled out following trial due to: □ Tried and considered appropriate Type of communication demonstrated: □ Spontaneous □ 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*****