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| **AAC Evaluation and Training Program**P.O. Box 5630Flagstaff, AZ 86011Phone: 928-523-4628Fax: 855-819-0087**Email:** **aacevalprogram@nau.edu****More information at** [**https://nau.edu/ihd/aac/**](https://nau.edu/ihd/aac/) |

Services available for Apache, Cochise, Coconino, La Paz, Maricopa, Mohave, Navajo, Pima, Pinal, and Yavapai Counties. We also offer remote evaluation and training services statewide.

**INSTRUCTIONS FOR COMPLETION OF THE AUGMENTATIVE AND ALTERNATIVE COMMUNICATION EVALUATION REFERRAL (AACER) PACKET (01/01/24)**

The Institute for Human Development (IHD) is a research and training center at Northern Arizona University and is part of a national network of University Centers for Excellence in Developmental Disabilities (UCEDD). IHD has more than 50 years of experience providing a range of programs for individuals with disabilities and more than 20 years of delivering augmentative communication services to children and adults.

**Please send the following documentation to** **aacevalprogram@nau.edu** **or by fax at 855-819-0087 to initiate your referral:**

**Required Documents**: This documentation must be provided or the process with be delayed.

[ ]  A **prescription** from the member’s Primary Care Physician for the AAC evaluation must indicate:

* + “AAC Device Evaluation”
	+ Physician’s National Provider Identifier (NPI)
	+ Member’s primary medical diagnosis ICD-10 code

[ ]  This NAU referral **packet**. This information will be used by medical review during the prior authorization process. The form should ideally be completed by a Speech-Language Pathologist. This background information is intended to prepare our teams to provide a thorough evaluation.

[ ]  Legible copies of both front and back of ALL **insurance cards**, including the AHCCCS card and any third-party payor card for private insurance. This includes Medicare. For Medicare, the member’s Social Security number is also REQUIRED.

[ ]  ***United Healthcare Community Plan*** insurance often requires documentation of speech services(eval or progress notes) for prior authorization. It is possible the signed NAU referral packet will satisfy insurance requirements if signed by a CCC-SLP. Please provide any current documentation and **our team will help you determine if additional documentation is needed.**

[ ]  ***United Healthcare Community Plan*** insurance require a copy of the most current **DDD Person Centered Service Plan (PCSP) Document.** If you do not have this information, please request it from the Support Coordinator.

We can help the team gather documentation if needed. Once all completed documentation is received, NAU will:

* Obtain prior authorization, if necessary.
* Call the family to schedule an intake appointment.
* Be responsible for training once the device is received and a training authorization is approved.

*Please Note: A device repair should be attempted first if the device is* ***less than three years old****.*

**AUGMENTATIVE AND ALTERNATIVE COMMUNICATION (AAC) EVALUATION REFERRAL (AACER) PACKET**

**Member Name *(Last, First, M.I.):*** Click or tap here to enter text.

**AHCCCS or Assists ID Number: A** Click or tap here to enter text.

**Date of Birth *(mm/dd/yyyy):*** Click or tap to enter a date. **Age:** Click or tap here to enter text.

**Parent/Guardian’s Name:** Click or tap here to enter text.

**Parent/Guardian’s Email Address:** Click or tap here to enter text.

**Parent/Guardian’s** **Address *(No., Street, City, State, Zip Code):*** Click or tap here to enter text.

*(If different from member)*

**Parent/Guardian’s Phone Number:** Click or tap here to enter text.
*(If different from member)*

**What language does the family speak?** Click or tap here to enter text.

**Does the family need an interpreter?** [ ] Yes [ ]  No

**Support Coordinator’s Name:** Click or tap here to enter text.

**Support Coordinator’s Email:** Click or tap here to enter text.

**Support Coordinator’s Phone:** Click or tap here to enter text.

**Name of School or Day Program:** Click or tap here to enter text.

**Details about this setting include (e.g. teacher, grade, least restrictive environment):**

Click or tap here to enter text.

**Member’s primary medical diagnoses and accompanying ICD-10 code(s) (*check all that apply)*:**

[ ]  F79.0 UNSPECIFIED INTELLECTUAL DISABILITY

[ ]  G40.301 EPILEPSY

[ ]  F84.0 AUTISM

[ ]  G80.9 CEREBRAL PALSY

[ ]  F88.0 DEVELOPMENTAL DELAY

[ ]  Q90.9 DOWN SYNDROME

[ ]  OTHER- Please include code: Click or tap here to enter text.

**Member’s Primary Care Physician (PCP):** Click or tap here to enter text.

**PCP Practice/Clinic Name:** Click or tap here to enter text.

**PCP Address:** Click or tap here to enter text.

**PCP Phone Number:** Click or tap here to enter text.

**PCP Fax Number:** Click or tap here to enter text.

**Member’s AHCCCS Managed Care Organization. This is your DDD ALTCS Medicaid Insurance Plan:**

[ ]  MercyCare *(This MCO* ***does not*** *require prior authorization.)*

[ ]  UnitedHealthCare Community Plan *(This MCO* ***does*** *require prior authorization.)*

[ ]  Tribal Health Plan (*This MCO* ***does*** *require prior authorization)*

**Does the individual have private, commercial insurance or Medicare?**

 [ ]  Yes [ ]  No

**Name of additional insurer:** Click or tap here to enter text.

[ ]  **If Medicare, Social Security number:** Click or tap here to enter text.

[ ]  **Required**: A copy of the third-party payor and/or Medicare Health Plan card, front and back.

**Speech-language diagnoses and accompanying ICD-10 code(s) *(check all that apply)*:**

[ ]  F80.2 EXPRESSIVE RECEPTIVE LANGUAGE DISORDER

[ ]  F80.1 EXPRESSIVE LANGUAGE DISORDER

[ ]  F80.0 ARTICULATION OR PHONOLOGICAL DISORDER

[ ]  R48.2 APRAXIA OF SPEECH

[ ]  R47.1 DYSARTHRIA/ANARTHRIA

[ ]  R13.1 DYSPHAGIA

[ ]  OTHER: Click or tap here to enter text.

**Explain in detail why a communication device is medically necessary for this member:**

Click or tap here to enter text.

**Does this member already have a device?** [ ]  Yes [ ]  No

 **If yes, what kind of device?** Click or tap here to enter text.

**Was the device purchased by the Division of Developmental Disabilities?** [ ]  Yes [ ]  No

**When was the device purchased?** Click or tap here to enter text.

**Did NAU recommend the device during a prior evaluation?** [ ]  Yes [ ]  No

**Why is the device no longer meeting the member’s needs?**

[ ]  Broken

[ ]  Obsolete hardware or software

[ ]  Member has had a change in medical status

[ ]  Member’s communication/language needs have changed

[ ]  Other: Click or tap here to enter text.

**Describe how the member uses their current device and assistance needed:**

Click or tap here to enter text.

**Did the member receive training on this device?** [ ]  Yes [ ]  No

**What experience does the member have using light-tech, aided AAC options?**

*(This information will be used by medical review during the prior authorization process. It is important to document trials, regardless of their success with these options.)*

[ ]  Physical object choices

[ ]  Eyegaze choice boards

[ ]  Direct selection picture choice boards

[ ]  Picture exchange cards or systems

[ ]  Printed word boards

[ ]  Communication books

[ ]  Battery-powered simple, short message devices

[ ]  Other: Click or tap here to enter text.

**Based on your interactions with the member, check the applicable boxes for each section below.**

**Gross Motor Skills**

**Ability to hold head up:** [ ]  Good [ ]  Fair [ ]  Poor

**Ability to sit without support:** [ ]  Good [ ]  Fair [ ]  Poor

**Muscle tone in arms/hands:** [ ]  Floppy [ ]  Average [ ]  Stiff [ ]  Varies

**Muscle tone in legs/feet:** [ ]  Floppy [ ]  Average [ ]  Stiff [ ]  Varies

**Walking ability:** [ ]  Independently [ ]  With assistance [ ]  Does not walk

**Balance:** [ ]  Steady [ ]  Fair [ ]  Poor [ ]  Falls frequently

**Mobility aids:** [ ]  AFO’s [ ]  Cane [ ]  Crutches [ ]  Walker [ ]  Scooter [ ]  Wheelchair

**If member uses wheelchair(s):**

[ ]  **Manual wheelchair**

**Brand Name and Model:** Click or tap here to enter text.

**Self-propels:** [ ]  Yes [ ]  No

**Stroller:** [ ]  Yes [ ]  No

[ ] **Power** **wheelchair**

**Brand Name and Model:** Click or tap here to enter text.

**Drives independently:** [ ]  Yes [ ]  No **Joystick control location:** Click or tap here to enter text.

**Describe any problems with the current wheelchair system:**

Click or tap here to enter text.

**Does the member have upcoming changes in his/her seating system?** [ ]  Yes [ ]  No

**Does the member use a tray with the wheelchair?** [ ]  Yes [ ]  No

**Are there any safety or other concerns related to mobility?** [ ]  Yes [ ]  No

**If needed, further describe the member’s gross motor skills:**

Click or tap here to enter text.

**Fine Motor Skills**

**Hand preference:** [ ]  Right [ ]  Left [ ]  Both [ ]  Unknown

**Ability to use hands:**

[ ]  Not able to use hands [ ]  Right only [ ]  Left only [ ]  With no difficulty [ ]  With limited movement/coordination

**Can pick up, hold, and manipulate**: [ ]  Cup [ ]  Spoon [ ]  Cookie [ ]  Goldfish cracker

**Can place and let go without dropping:** [ ]  Cup [ ]  Spoon [ ]  Cookie [ ]  Goldfish cracker

**Can open and close:** [ ]  Buttons [ ]  Zippers [ ]  Tie shoelaces

**Can point and press buttons of the size found on**: [ ]  Pop machines [ ]  Elevators [ ]  Toys

**Can select icons on tablets or phones:** Yes No

**Completes writing tasks with *(check all that apply)*:**

[ ]  Unable to write [ ]  Regular pen [ ]  Adapted pen [ ]  Standard keyboard [ ]  On-screen keyboard

**Uses other body parts to communicate:**

[ ]  Head [ ]  Eyes [ ]  Leg [ ]  Arm [ ]  Hand [ ]  Mouth stick [ ]  Head stick [ ] Other:

**Uses adaptive switches to manipulate and control things:** [ ]  Yes [ ]  No

**If yes, indicate types of switches, where they are placed, and what activities they are used for:**

Click or tap here to enter text.

**If needed, further describe the member’s fine motor skills:**

Click or tap here to enter text.

**Hearing and Vision**

**Hearing is functional:** [ ]  Yes [ ]  No

**If no:** [ ]  Sensorineural [ ]  Conductive [ ]  Mixed [ ]  Unknown

[ ]  Right ear [ ]  Left ear [ ]  Both ears

**Does the member use assistive hearing devices?** [ ]  Yes [ ]  No

**If yes, what devices:** Click or tap here to enter text.

**Vision is functional:** [ ]  In bright light [ ]  In low light [ ]  No functional vision

**Does the member wear eyeglasses?** [ ]  Yes [ ]  No

**If yes, will they wear eyeglasses during the evaluation?** [ ]  Yes [ ]  No

**If the member is considered cortically blind**:

**Where are they on the CVI range, if known?** Click or tap here to enter text.

**Describe the member’s visual function:** Click or tap here to enter text.

**Member can see pictures that are:** [ ]  Color [ ]  Black/white [ ]  Large [ ]  Small [ ]  Unknown

**Can member follow movement with:** [ ]  Right eye [ ]  Left eye [ ]  Both eyes [ ]  Not at all [ ]  Unknown

**Describe visual tracking ability:** Click or tap here to enter text.

**Is the member easily distracted by visual stimulation?** [ ]  Yes [ ]  No

**The member is currently selecting an individual icon from a visual display of:**

[ ]  Not applicable - Cannot select [ ]  2 to 5 icons [ ]  5 to 10 icons [ ]  10 to 20 icons [ ]  20 to 40 icons [ ]  40 or more icons

**If needed, further describe the member’s hearing and vision:**

Click or tap here to enter text.

**Behavior Modulation**

**How long can the member maintain their attention to task:**

**For preferred activity:** Click or tap here to enter text.

**For non-preferred activity:** Click or tap here to enter text.

**Behaviors observed (*check all that apply*):**

[ ]  Repetitive actions/movements [ ]  Self-injury [ ]  Aggression [ ]  Property destruction [ ]  Sensory seeking

[ ]  Sensory aversions

 [ ]  Unfamiliar/unexpected touch [ ]  Touching items [ ]  Textures [ ]  Odors [ ]  Noise [ ]  Lights

[ ]  Certain foods [ ]  Other: Click or tap here to enter text.

Describe the typical reaction: Click or tap here to enter text.

**Describe possible effect of any behaviors on evaluation:** Click or tap here to enter text.

**Typical activity level:** [ ]  Low/quiet [ ]  Average [ ]  High/very active

**Does this member currently have a “Behavior Support Plan”?** [ ]  Yes [ ]  No

**Does the member receive behavior support services (e.g. ABA)?** [ ]  Yes [ ]  No

**Response to unfamiliar people/places:**

[ ]  No significant reaction [ ]  Withdrawal [ ]  Run away [ ]  Interested/engaged [ ]  Over-excitement

**Describe any current strategies used within sessions to support engagement (e.g. picture schedules, timers, first/then):** Click or tap here to enter text.

**Please recommend 3 highly motivating, preferred items and/or activities for the evaluation (e.g. specific food, social praise, cartoon characters, toys, videos):**

1. Click or tap here to enter text. 2. Click or tap here to enter text. 3. Click or tap here to enter text.

**Speech Production**

**Prognosis for functional speech production within the next 12 months:** [ ]  Good [ ]  Fair [ ]  Poor

**Explain prognosis:** Click or tap here to enter text.

**Current speech production:** [ ] Vocalizations [ ] One word [ ] Simple phrases [ ] Sentences [ ] Conversational speech

**Percentage of intelligible speech for:**

**Familiar listeners:** Context Known \_\_\_% Context Unknown\_\_\_\_%

**Non-familiar listeners:** Context Known \_\_\_\_% Context Unknown\_\_\_\_%

**Oral-motor structures and movements are functional for speech production:** [ ]  Yes [ ]  No

**Has an oral-motor exam, formal or informal, been performed?** [ ]  Yes [ ]  No

**If so, describe strength, muscle tone, coordination and any impairments of speech articulators (e.g. lips, tongue, palate):** Click or tap here to enter text.

**Swallowing/feeding concerns:** [ ]  Yes [ ]  No

**Saliva management concerns:** [ ]  Yes [ ]  No
**Respiration/breathing concerns:** [ ]  Yes [ ]  No

**Are there any other significant issues in relation to the production of speech?** [ ]  Yes [ ]  No

**If yes, describe:** Click or tap here to enter text.

**Communication: Understanding**

**Does the member respond to their own name?** [ ]  Yes [ ]  No

**Do they comprehend when told “Yes”?** [ ]  Yes [ ]  No

**Do they comprehend when told “No”?** [ ]  Yes [ ]  No

**Demonstrates understanding:**

**Basic cause/effect** [ ]  Yes [ ]  No **List:** Click or tap here to enter text.

**Body parts** [ ]  Yes [ ]  No **List:** Click or tap here to enter text.

**Prepositions** [ ]  Yes [ ]  No **List:** Click or tap here to enter text.

**Quantities** [ ]  Yes [ ]  No **List:** Click or tap here to enter text.

**Categories** [ ]  Yes [ ]  No **List:** Click or tap here to enter text.

**Sequencing** [ ]  Yes [ ]  No **List:** Click or tap here to enter text.

**Follows directions:**

[ ]  Simple [ ]  Complex [ ]  Familiar routines/activities [ ]  Unfamiliar routines/activities [ ]  1-step [ ]  2-step [ ]  Multi-step

**If needed, further describe member’s communicative understanding and receptive language skills:**

Click or tap here to enter text.

**Communication: Expression**

**Makes choices:** [ ]  Not at all [ ]  Inconsistent [ ]  Consistent

**Asks questions:** [ ]  Not at all [ ]  Inconsistent [ ]  Consistent

**Describes a sequence of events:** [ ]  Not at all [ ]  Inconsistent [ ]  Consistent

**Expresses feelings and emotions:** [ ]  Not at all [ ]  Inconsistent [ ]  Consistent

**Answers yes/no questions:** [ ]  Not at all [ ]  Inconsistent [ ]  Consistent

**Answers questions given choices:** [ ]  Not at all [ ]  Inconsistent [ ]  Consistent

**Answers open-ended questions:** [ ]  Not at all [ ]  Inconsistent [ ]  Consistent

**Communicates successfully using:**

[ ]  Speech production [ ]  Complete words [ ]  Incomplete words [ ]  Echolalia [ ]  Scripting [ ]  Vocalizations

[ ]  Eye gaze [ ]  Body language [ ]  Gestures [ ]  Facial expressions [ ]  Sign language [ ]  Picture symbol board

[ ]  Spelling/word board [ ]  Communication device [ ]  Behavior (socially appropriate or challenging)

[ ]  Other: Click or tap here to enter text.

**If needed, further describe member’s expressive communication and language skills:**

Click or tap here to enter text.

**Social Interaction**

**How does the member gain attention to initiate communication?** Click or tap here to enter text.

**Mark the statements below that best describe observable social interaction behaviors. Check all that apply.**

[ ]  Reacts to familiar people and/or motivating activities.

[ ]  Takes turns in familiar and motivating routines (e.g., “high five” or when someone spreads arms to receive a hug).

[ ]  Responds to close physical interaction by looking, smiling, or reaching.

[ ]  Shows clear preference for certain objects, activities, and people.

[ ]  Starting to show some interest in social interactions, especially in specific situations.

[ ]  Does not use symbols to interact socially.

[ ]  Initiates conversations and social interactions with familiar communication partners.

[ ]  Benefits from help to take additional turns in conversation.

[ ]  Uses turn taking independently.

Answers routine questions appropriately with: [ ]  Familiar communication partners [ ]  A variety of communication partners

[ ]  Uses socially appropriate comments/questions to initiate with familiar communication partners.

[ ]  Social interaction skills, environments, and activities are similar to others of their age.

**If needed, further describe member’s social interaction skills:**

Click or tap here to enter text.

**Literacy Skills**

**Mark the statements below that best describe observable literacy skills. Check all that apply.**

[ ]  Does not appear interested in reading or book activities.

[ ]  Demonstrates a beginning interest in participating in shared reading and/or is beginning to engage with books more

 independently.

[ ]  Able to identify own name and a few other frequently seen words.

[ ]  Literacy skills growing to include: identifying letters of the alphabet, connecting some letters with corresponding sounds,

 understanding word boundaries, reading a small number of high frequency sight words, reading and writing name,

 beginning to spell words but not necessarily with conventional spelling.

[ ]  Literacy skills growing to include: increased letter-sound awareness, additional sight words, conventional spelling of

 simple words; adding word endings as appropriate (e.g., past tense “ed”, plural “s” or “ing), and solid understanding of

 the connection between spoken words and print.

[ ]  Beginning to utilize word prediction with symbol support.

[ ]  Reads printed material that is somewhat below an age-appropriate level.

[ ]  Literacy abilities are on par with same-age peers.

**If needed, further describe member’s literacy skills:**

Click or tap here to enter text.

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| --- |
| **REFERRING SLP: Name *(Last, First):*** Click or tap here to enter text. [ ] **CCC-SLP** [ ] **CF-SLP** [ ] **SLPA** If CF or SLPA, name of supervising SLP who reviewed this form: Click or tap here to enter text.Phone Number: Click or tap here to enter text.Email Address: Click or tap here to enter text. Employer Name: Click or tap here to enter text. How long have you treated the member? Click or tap here to enter text. Do you think this client is a good candidate for a remote evaluation? [ ]  Yes [ ]  No**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_****Supervisor Signature (if needed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_** |