INSTRUCTIONS FOR COMPLETION OF THE AUGMENTATIVE ALTERNATIVE COMMUNICATION REFERRAL PACKET BY A CERTIFIED SPEECH-LANGUAGE PATHOLOGIST

PRIOR TO COMPLETION OF THE AAC REFERRAL PACKET, THE SLP MUST INFORM THE SUPPORT COORDINATOR THAT AN AAC EVALUATION HAS BEEN DETERMINED MEDICALLY NECESSARY FOR THE MEMBER

AAC Referral Packet Contents:

1) Demographic Information.
2) ISP Information: Attach a copy of the most current ISP. If you do not have this information, you will need to request the ISP from the Support Coordinator. The ISP must be submitted with the Packet. If the member does not have an ISP and they are under the age of 3, an IFSP must be submitted.
3) Insurance Information: Include a legible copy of any third party payor card, both front and back (this is the member's private insurance). This includes Medicare. If you do not have this information, you will need to request this from the Support Coordinator. A copy of the insurance card must be submitted with the Packet. The AHCCCS card is not required upon submission.
4) Evaluator Choice: The Speech Language Pathologist will ask the member which provider they would like to have perform the evaluation and training. THIS MUST BE FAMILY CHOICE. In addition, remind the family that the team completing the evaluation will be responsible for the training as well.
5) Communication Skills Questionnaire (CSQ): Must be completed by a Speech-Language Pathologist holding their Certificate of Clinical Competence (CCC). If you are a CF or SLP-A, the CSQ must be cosigned by your supervising Speech-Language Pathologist. Add as much description as possible to assist the evaluators in providing a thorough evaluation. IF your recommendation is that the member would benefit from a communication device, you must explain why in detail.
6) **The SLP will give the completed packet back to the family so that they may obtain the signature and office notes from the face-to-face visit with their physician.**
7) The family will submit the signed Packet to the SLP or Support Coordinator for submission. The SLP or Support Coordinator may submit the Packet via email to the AAC inbox.

ADDITIONAL INFORMATION FOR SCHOOL SYSTEMS:

1) CSQs completed by school SLPs: Complete the CSQ in its entirety and submit to DDDAugComms@azdes.gov. The Augmentative Alternative Communication Unit will obtain the remaining information (ISP, insurance, etc.). **The Support Coordinator is responsible for giving the packet back to the family to obtain a signature from their physician.**
2) If the school is completing the AAC evaluation, this Packet does not need to be completed. The school system should send the evaluation, including quote page, to DDDAugComms@azdes.gov.

PACKET MUST BE COMPLETED IN ITS ENTIRETY OR THE PROCESS WILL BE DELAYED

Send completed packet to **DDDAugComms@azdes.gov**.
For mail options, contact the AAC Department for further instructions via the above email address.

AUGMENTATIVE ALTERNATIVE COMMUNICATION (AAC) REFERRAL PACKET

MUST BE COMPLETED IN ITS ENTIRETY

DATE HCS RECEIVED PACKET

MEMBER INFORMATION

Name *(Last, First, M.I.)* _____

AHCCCS or Assists ID Number _____ Age _____ Date of Birth *(mm/dd/yyyy)* _____

Address *(No., Street)* _____

City _____ State _____ ZIP Code _____ Phone Number _____

Parent/Guardian's Name _____ Email Address _____

Address *(No., Street)* _____
(If different from members)

City _____ State _____ ZIP Code _____ Phone Number _____
(If different from member)

Support Coordinator's Name _____

What is the Member's diagnosis? _____

Who is the Member's PCP? _____

What language does the family speak? _____ Does the family need an interpreter? _____

☐ 2) A copy of the most current Individual Support Plan (ISP) or IFSP, if applicable. Attached ☐ Yes

☐ 3) Does the individual have private health care insurance or Medicare? ☐ Yes ☐ No

☐ 4) A legible photocopy of the third party payor card and/or Medicare Health Plan ID card, front and back. **Required**.
Attached ☐ Yes

CONTRACTED PROVIDERS *(This must be family choice)*

5) Check (✓) which provider the member/family chooses to administer the Augmentative Communication evaluation.

☐ **Member would like the Division to auto-select a vendor**
The Division will assign a vendor based on an automatic assignment process

☐ **Advanced Therapy Solutions**
Services available for Maricopa, Pima, Yavapai, Pinal, Cochise, Gila, and Yuma Counties

☐ **MileMarkers Therapy**
Services available for LaPaz and Mohave Counties

☐ **NAU/Institute for Human Development**
Services available for Apache, Cochise, Coconino, Maricopa, Mohave, Navajo, Pima, Pinal, and Yavapai Counties

☐ **Therapy One**
Services available for all counties

COMMUNICATION SKILLS QUESTIONNAIRE (CSQ)
Speech – Language Pathologist *(to fill out below)*

Name *(Last, First)* _____ Phone Number _____

Employer Name _____ Email Address _____

How long have you treated the Member? _____ Frequency/Amount _____

Has the member received at least six months of speech therapy at any time? ☐ Yes ☐ No

Please list date range: _____

SIGNATURE	Please Circle:	DATE SIGNED
_____	CCC/SLP or CCC/SLP-L	_____
CO-SIGNATURE *(If applicable)*	Please Circle:	DATE SIGNED
_____	CF or SLP-A	_____

Is your recommendation that the Member would benefit from a communication device? ☐ Yes ☐ No

Explain in detail why or why not ***(Required)***:

If your recommendation is yes the member would benefit from a device fill out the questions below. If your recommendation is no, return this form to the member's Support Coordinator so they may complete a Notice of Adverse Determination. The below information does not need to be completed.

Does this Member already have a device? ☐ Yes ☐ No

Was this device purchased by the Division? ☐ Yes ☐ No

If yes, what kind of device? _____

Is this device being used in all settings? ☐ Yes ☐ No

Is this device being used solely as a communication device? ☐ Yes ☐ No

Is the Member resistant to using this or any other device? ☐ Yes ☐ No

Describe the resistance: _____

Does this Member require assistance to use the device? ☐ Yes ☐ No

Describe the assistance needed: _____

Did the member receive training on this device? ☐ Yes ☐ No

If so, please provide documentation of training.

Is this a request for re-evaluation? ☐ Yes ☐ No If yes, describe why:

Complete the information below. You may consult with family/therapists. Please add as much descriptive information as possible to assist the evaluators in providing a thorough evaluation.

Based on your interactions with the Member check the applicable boxes below *(Check all that apply)*

Ability to hold head up: ☐ Good ☐ Fair ☐ Poor

Describe: _____

Ability to sit without support: ☐ Good ☐ Fair ☐ Poor

Describe: _____

Muscle tone in arms/hands: ☐ Floppy ☐ Average ☐ Stiff ☐ Varies

Describe: _____

Muscle tone in legs/feet: ☐ Floppy ☐ Average ☐ Stiff ☐ Varies

Describe: _____

Walking ability: ☐ Independently ☐ With assistance ☐ Does not walk

Describe: _____

Balance: ☐ Steady ☐ Fair ☐ Poor ☐ Falls frequently

Describe: _____

Mobility aides: ☐ AFO's ☐ Cane ☐ Crutches ☐ Walker ☐ Scooter ☐ Wheelchair

☐ Other: _____

Describe: _____

If member uses a wheelchair(s):

☐ Manual - Type: _____

Self-propels: ☐ Yes ☐ No Stroller: ☐ Yes ☐ No

☐ Power - Type: _____

Drives independently: ☐ Yes ☐ No Joystick control location: _____

Describe: _____

Describe any problems with the current wheelchair system:

Does the member have upcoming changes in his/her seating system? ☐ Yes ☐ No

Explain: _____

Does the member use a tray with the wheelchair? ☐ Yes ☐ No

Describe: _____

Are there any safety or other concerns related to mobility? ☐ Yes ☐ No

Describe:

Hand preference: ☐ Right ☐ Left ☐ Both ☐ Unknown

Describe: _____

Ability to use hands: ☐ Not able to use hands ☐ Right only ☐ Left only

☐ With no difficulty ☐ With limited movement/coordination

Describe: _____

Can pick up and hold: ☐ Cup ☐ Spoon ☐ Cookie ☐ Raisin

Describe: _____

Can place and let go without dropping: ☐ Cup ☐ Spoon ☐ Cookie ☐ Raisin

Describe: _____

Can open and close: ☐ Buttons ☐ Zippers ☐ Tie shoelaces

Describe: _____

Can point and press buttons of the size found on: ☐ Pop machines ☐ Elevators ☐ Telephones

Describe: _____

Member throws things: ☐ Not usually ☐ Sometimes ☐ Often ☐ Not at all

Describe: _____

Completes writing tasks with *(check all that apply)*: ☐ Unable to write ☐ Regular pen ☐ Adapted pen

☐ Keyboard ☐ Other writing aides (dragon): _____

Describe: _____

Uses other body parts to communicate: ☐ Head ☐ Eyes ☐ Leg ☐ Arm ☐ Hand

☐ Mouth stick ☐ Head stick ☐ Other: _____

Describe: _____

Uses 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:

_____

Hearing is functional: ☐ Yes ☐ No

Describe: _____

Does the member use assistive hearing devices? ☐ Yes ☐ No

If yes, what devices: _____

Is the member easily distracted by noisy environments? ☐ Yes ☐ No

If yes, list the environment: _____

Vision is functional: ☐ In bright light ☐ In low light ☐ No functional vision

Describe: _____

Does the member wear eye-glasses? ☐ Yes ☐ No

Comments: _____

If the member is considered cortically blind, describe the visual function: _____

Can member see pictures that are: ☐ Color ☐ Black/white ☐ Large ☐ Small ☐ Unknown

Describe: _____

Can member follow movement with: ☐ Right eye ☐ Left eye ☐ Both eyes ☐ Not at all ☐ Unknown

Describe visual tracking ability: _____

Describe member's eye contact:

How long can the member maintain their attention? _____

Is the member easily distracted by visual stimulation? ☐ Yes ☐ No

Describe: _____

Is the member overly sensitive to: ☐ Unfamiliar/unexpected touch ☐ Touching items ☐ Textures
☐ Odors ☐ Noise ☐ Lights ☐ Certain foods

Describe the typical reaction: _____

Typical activity level: ☐ Low/quiet ☐ Average ☐ High/very active

Describe: _____

Behaviors observed: ☐ Self-stimulation ☐ Self-injury ☐ Aggression ☐ Property destruction

Describe behavior, frequency and when it appears:

Does this member currently have a "Behavior Support Plan"? ☐ Yes ☐ No

Response to unfamiliar people/places: ☐ No significant reaction ☐ Withdrawal ☐ Run away ☐ Interested/engaged ☐ Over-excitement

Describe reaction: _____

Motivators, reinforcers, or rewards that work: ☐ Attention/social praise ☐ Tangibles (e.g. toy, edible) ☐ Escape

☐ Other: _____

Describe: _____

Ability to follow simple directions: ☐ Good ☐ Fair ☐ Poor ☐ Inconsistent

Describe: _____

Ability to follow multi-step instructions: ☐ Good ☐ Fair ☐ Poor ☐ Inconsistent

Describe: _____

Prognosis for functional speech production within the next 12 months: ☐ Good ☐ Fair ☐ Poor

Explain: _____

Current speech production: ☐ Vocalizations ☐ One word ☐ Simple phrases ☐ Sentences ☐ Conversational speech

Describe in detail:

Percentage of intelligible speech for: _____ % Familiar listeners _____ % Non-familiar listeners

Describe: _____

Oral-motor structures and movements are functional for speech production: ☐ Yes ☐ No

If no, describe:

Swallowing/feeding concerns: ☐ Yes ☐ No

If yes, describe:

Drooling: ☐ Yes ☐ No

If yes, describe:

Respiration/breathing concerns: ☐ Yes ☐ No
If yes, describe:

Are there any other significant issues in relation to the production of speech? ☐ Yes ☐ No
If yes, describe:

Member presently communicates using *(check all that apply)*:

☐ Complete words	☐ Incomplete words	☐ Vocalizations	☐ Echolalia
☐ Eye gaze	☐ Gestures	☐ Facial expressions	☐ Sign language
☐ Picture symbol board	☐ Scripted	☐ Spelling/word board	☐ Speech
☐ Communication device	☐ Other: _____		

Initiates communication: ☐ Not at all ☐ Inconsistent ☐ Consistent
Describe:

Responds to communication: ☐ Not at all ☐ Inconsistent ☐ Consistent
Describe:

Gains attention: ☐ Not at all ☐ Inconsistent ☐ Consistent
Describe:

Expresses wants and needs: ☐ Not at all ☐ Inconsistent ☐ Consistent
Describe:

Makes choices: ☐ Not at all ☐ Inconsistent ☐ Consistent
Describe:

Asks questions: ☐ Not at all ☐ Inconsistent ☐ Consistent
Describe:

Describes a sequence of events: ☐ Not at all ☐ Inconsistent ☐ Consistent
Describe:

Expresses feelings and emotions: ☐ Not at all ☐ Inconsistent ☐ Consistent
Describe:

Uses repair strategies: ☐ Not at all ☐ Inconsistent ☐ Consistent
Describe:

Uses turn taking: ☐ Not at all ☐ Inconsistent ☐ Consistent
Describe:

Follows directions: ☐ Not at all ☐ Inconsistent ☐ Consistent
Describe:

Understands social routines and humor: ☐ Not at all ☐ Inconsistent ☐ Consistent
Describe:

Recognizes/discriminates symbols/pictures: ☐ Not at all ☐ Inconsistent ☐ Consistent
Describe:

Reads: ☐ Not at all ☐ Inconsistent ☐ Consistent
Describe:

Spells: ☐ Not at all ☐ Inconsistent ☐ Consistent
Describe:

Member demonstrates comprehension of:

Own name: ☐ Yes ☐ No
Explain:

"Yes": ☐ Yes ☐ No
Explain:

"No": ☐ Yes ☐ No
Explain:

Object identification: ☐ Yes ☐ No List: _____
Explain:

Object function: ☐ Yes ☐ No List: _____
Explain:

1-step requests/directions: ☐ Yes ☐ No
Explain:

2-step requests/directions: ☐ Yes ☐ No
Explain:

Multi-step requests/directions: ☐ Yes ☐ No
Explain:

Body parts: ☐ Yes ☐ No List: _____
Explain:

Prepositions: ☐ Yes ☐ No List: _____
Explain:

Quantity: ☐ Yes ☐ No List: _____
Explain:

Categories: ☐ Yes ☐ No List: _____
Explain:

Sequencing: ☐ Yes ☐ No List: _____
Explain:

Physician *(to fill out below)*

I, _____, have read this document in its entirety and agree with the recommendation that a speech generating device and the accompanying training are medically necessary. The face-to-face encounter occurred on _____. I have attached the visit notes and records that pertain to the primary reason the beneficiary requires this durable medical equipment.

Signature _____ NPI _____ Date Signed _____