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| **AAC Evaluation and Training Program**  P.O. Box 5630  Flagstaff, AZ 86011  Phone: 928-523-4628  Fax: 855-819-0087  **Email:** [**aacevalprogram@nau.edu**](mailto: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**](mailto: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: \_\_\_\_\_\_\_\_\_\_\_** |