

AAC Evaluation and Training Program

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More information at <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 acevalprogram@nau.edu or by fax at 855-819-0087 to initiate your referral:

Required Documents: This documentation must be provided or the process will 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.):

AHCCCS or Assists ID Number: A

Date of Birth (mm/dd/yyyy): .

Age:

Parent/Guardian's Name:

Parent/Guardian's Email Address:

Parent/Guardian's Address (No., Street, City, State, Zip Code):

(If different from member)

Parent/Guardian's Phone Number:

(If different from member)

What language does the family speak?

Does the family need an interpreter? Yes No

Support Coordinator's Name:

Support Coordinator's Email:

Support Coordinator's Phone:

Name of School or Day Program:

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

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:

Member's Primary Care Physician (PCP):

PCP Practice/Clinic Name:

PCP Address:

PCP Phone Number:

PCP Fax Number:

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:

If Medicare, Social Security number:

Required: A copy of the third-party payer 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:

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

Does this member already have a device? Yes No

If yes, what kind of device?

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

When was the device purchased?

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:

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

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:

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: .

Self-propels: Yes No

Stroller: Yes No

Power wheelchair

Brand Name and Model:

Drives independently: Yes No Joystick control location:

Describe any problems with the current wheelchair system:

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:

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:

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

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:

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?

Describe the member's visual function:

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:

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:

Behavior Modulation

How long can the member maintain their attention to task:

For preferred activity:

For non-preferred activity:

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:

Describe the typical reaction:

Describe possible effect of any behaviors on evaluation:

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):

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

1.

2.

3.

Speech Production

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

Explain prognosis:

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):

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:

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:

Body parts Yes No List:

Prepositions Yes No List:

Quantities Yes No List:

Categories Yes No List:

Sequencing Yes No List:

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:

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:

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

Social Interaction

How does the member gain attention to initiate communication?

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:

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:

REFERRING SLP: Name (Last, First): _____ CCC-SLP CF-SLP SLPA

If CF or SLPA, name of supervising SLP who reviewed this form:

Phone Number: _____

Email Address: _____

Employer Name: _____

How long have you treated the member? _____

Do you think this client is a good candidate for a remote evaluation? Yes No

Signature: _____ **Date:** _____

Supervisor Signature (if needed): _____ **Date:** _____