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| **AAC Evaluation and Training Program**P.O. Box 5630Flagstaff, AZ 86011Phone: 928-523-6759 928-523-4628Fax: 855-819-0087**Email:** **aacevalprogram@nau.edu** |

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 (06/08/21)**

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** **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. Must be completed by a Speech-Language Pathologist holding their Certificate of Clinical Competence (CCC) in conjunction with the family and service team. For CF or SLP-A, the packet must be cosigned by the supervising 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.

[ ]  Some insurances require a copy of the most recent (preferably within 12 months) **speech-language evaluation or documentation of current speech services** (progress notes) for prior authorization. It is possible the signed NAU referral packet will satisfy insurance requirements. Please provide any current documentation and our team will help you determine if additional documentation is needed.

[ ]  Some insurances require a copy of the most current **Individualized Service Plan (ISP)/Individualized Family Service Plan (IFSP)/Planning 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 at aacevalprogram@nau.edu, NAU will:

* Call the family to schedule an intake appointment.
* Obtain prior authorization, if necessary.
* 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 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.

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

**Phone Number:** 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

[ ]  F84.2 RETT SYNDROME

[ ]  OTHER: 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:**

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

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

**Does the individual have private health care insurance or Medicare?** [ ]  Yes [ ]  No

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

*(All private insurance requires prior authorization.)*

[ ]  **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.

**Does this Member require assistance to use the device?** [ ]  Yes [ ]  No

**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 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.

**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.**

[ ]  Is not 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. **Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_** |