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

**AHCCCS or Assists ID Number: A**

**Date of Birth *(mm/dd/yyyy):***  **Age:**

**Address *(No., Street, City, State, Zip Code):***

**Phone Number:**

**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

F84.2 RETT SYNDROME

OTHER:

**Member’s Primary Care Physician (PCP):**

**PCP Practice/Clinic Name:**

**PCP Address:**

**PCP Phone Number:**

**PCP Fax Number:**

**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:**

*(All private insurance requires prior authorization.)*

**If Medicare, Social Security number:**

**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:

**Explain 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:

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

**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

**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 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):**

**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.**

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:**

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| **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?  **Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_** |