Clear Form

Minnesota Department of **Human Services**

DHS-4535-ENG 8-11

Minnesota Health Care Programs (MHCP)

Augmentative Communication Devices and Accessories Authorization Form

ASSIGNED NUMBER FROM MN–ITS

Use this form in addition to the MN–ITS Authorization Request transaction or the Authorization Form (DHS-4695) to request authorization for augmentative communication devices and accessories. Fax this form with any additional or required documentation to the medical review agent.

If more space is needed, continue answer on separate sheet and indicate question you are answering.

Provider Information

PROVIDER NAME	NPI/UMPI
CONTACT NAME	PHONE NUMBER ( )

Recipient Information

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	MHCP ID NUMBER

DIAGNOSIS	SPEECH DIAGNOSIS

GENERAL MEDICAL HISTORY AND CURRENT MEDICAL STATUS

CURRENT HEARING STATUS	WITHIN NORMAL LIMITS WITH CORRECTION ☐ Yes ☐ No

Hearing status influences the recipient's communication and/or choice of device ☐ Yes ☐ No

EXPLAIN

CURRENT VISION STATUS	WITHIN NORMAL LIMITS WITH CORRECTION ☐ Yes ☐ No

Vision status influences the recipient's communication and/or choice of device ☐ Yes ☐ No

EXPLAIN

EDUCATIONAL STATUS		
GRADE	SPECIAL ED	EDUCATIONAL LEVEL COMPLETED

EMPLOYED	UNEMPLOYED DUE TO DISABILITY	DAY PROGRAM	EXPLAIN AS NECESSARY
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	

LEVEL OF THERAPY/SERVICE				
Type of Therapy or Service	Frequency #/month	Duration	Site (outpatient, school, etc.)	Objectives

PSYCHOLOGICAL ASSESSMENT AND STATUS			
Standardized Assessment Tool	Results/Developmental Level	Evaluator	Date of Test
Non-Standard Testing	Results/Developmental Level	Evaluator	Date of Test

Evaluation Team

Indicate who provided information for this evaluation and type of input.

NAME	SLP	CREDENTIALS	LICENSE/REG #	REPORT ONLY ☐ Yes ☐ No PARTICIPATION ☐ Yes ☐ No
NAME	PT/OT	CREDENTIALS	LICENSE/REG #	REPORT ONLY ☐ Yes ☐ No PARTICIPATION ☐ Yes ☐ No
NAME	PSYCH	CREDENTIALS	LICENSE/REG #	REPORT ONLY ☐ Yes ☐ No PARTICIPATION ☐ Yes ☐ No
NAME	OTHER	CREDENTIALS	LICENSE/REG #	REPORT ONLY ☐ Yes ☐ No PARTICIPATION ☐ Yes ☐ No

Speech and Language Status, Evaluated by SLP

Communication Assessment, include both expressive and receptive testing results.

Standardized Assessment Tool	Results/Developmental Level	Evaluator	Date of Test
Non-Standard Testing	Results/Developmental Level	Evaluator	Date of Test
Oral examination text instrument used			
Prognosis for functional oral speech			

Communication Technology Experience

Include or attach recipient's language sample with and without technology. May attach report. Indicate if recipient has no experience, unable, past experience only, current use limited, current use functional.

Explanation	Outcome
GESTURES	
WRITTEN COMMUNICATION	
SIGN LANGUAGE	
WORD/PICTURE/SYMBOL BOARD: _____ # Words _____ # Pictures _____ # Symbols _____ # Phrases _____ # Sentences	
WORD/PICTURE/SYMBOL BOARD: _____ # Words _____ # Pictures _____ # Symbols _____ # Phrases _____ # Sentences	
WORD/PICTURE/SYMBOL BOARD: _____ # Words _____ # Pictures _____ # Symbols _____ # Phrases _____ # Sentences	
OTHER (Describe)	

Motor/Postural/Mobility Status

Indicate any limitation of motor, posture or mobility skills that affect the choice course of a communication device.

Functional ambulation/mobility	
☐ Independent ambulation	☐ Modified independent (devices, limited distance/control) specify:
☐ Dependent manual wheelchair user	☐ Power wheelchair user
☐ Manual wheelchair user - functionally independent	☐ Current wheelchair user, but to be changed in near future

Communication device to be used in the following positions – check all that apply	
☐ Standing or walking	☐ Lying prone or supine
☐ Seated in wheelchair	☐ Posture not corrected with seating system, specify limitations:
☐ Seated, other than wheelchair	☐ Other
Control of access is affected by positioning ☐ Yes ☐ No EXPLAIN:	

Recipient ability to access communication device	
☐ No limitation	☐ Able, but requires accommodation
☐ Able, but unwanted activation and errors	☐ Unable
☐ Able, but requires extra time and effort	

Limited/impaired ability to access due to – check all that apply		
☐ Impaired vision		☐ Impaired strength or range
☐ Decreased sensation		☐ Abnormal or fluctuating muscle tone
☐ Other	DESCRIBE SEVERITY/TYPE	

Access/control type currently used
☐ Direct select without modification
☐ Direct select with modification, specify:
☐ Single switch, specify type and site:
☐ Multiple switch, specify type and sites:
Device will be integrated with other technology (w/c controls) ☐ Yes ☐ No
Wheelchair will mount or other will be required ☐ Yes ☐ No
Recipient transfers in/out of wheelchair independently ☐ Yes ☐ No EXPLAIN:

Rationale for Prescribed Communication Device

Identify all communication devices considered for the recipient. Consider a range of low to high tech, as appropriate. The recommended device must be the least costly alternative that meets the recipient's need for functional communication.

DEVICE Describe setup and any modifications or accommodations	☐ Ruled out without trying due to:
	☐ Ruled out following trial due to:
	☐ Trialed and considered appropriate
	TYPE OF COMMUNICATION DEMONSTRATED ☐ Spontaneous ☐ Response
______ # Words ______ # Pictures ______ # Symbols ______ # Phrases ______ # Sentences	
DEVICE Describe setup and any modifications or accommodations	☐ Ruled out without trying due to:
	☐ Ruled out following trial due to:
	☐ Trialed and considered appropriate
	TYPE OF COMMUNICATION DEMONSTRATED ☐ Spontaneous ☐ Response
______ # Words ______ # Pictures ______ # Symbols ______ # Phrases ______ # Sentences	
DEVICE Describe setup and any modifications or accommodations	☐ Ruled out without trying due to:
	☐ Ruled out following trial due to:
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	TYPE OF COMMUNICATION DEMONSTRATED ☐ Spontaneous ☐ Response
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DEVICE Describe setup and any modifications or accommodations	☐ Ruled out without trying due to:
	☐ Ruled out following trial due to:
	☐ Trialed and considered appropriate
	TYPE OF COMMUNICATION DEMONSTRATED ☐ Spontaneous ☐ Response
______ # Words ______ # Pictures ______ # Symbols ______ # Phrases ______ # Sentences	

RECIPIENT AND CAREGIVER PREFERENCE FOR DEVICE MUST DOCUMENT MEDICAL NECESSITY TO SUPPORT THIS REQUEST

Current Communication Behaviors

☐ RESPONDS TO QUESTIONS ONLY	☐ SPONTANEOUSLY INITIATES OCCASIONALLY % and detail any prompting	☐ SPONTANEOUSLY INITIATES IN A VARIETY OF SETTINGS % for each setting and detail any prompting

Demonstrated Communication Behaviors with Recommended Device

☐ RESPONDS TO QUESTIONS ONLY	☐ SPONTANEOUSLY INITIATES OCCASIONALLY % and detail any prompting	☐ SPONTANEOUSLY INITIATES IN A VARIETY OF SETTINGS % for each setting and detail any prompting

Requested Device, Components and Vendor (model number and pricing)

If proposed device is to be a replacement for a device that is:

- No longer operational, include documentation from manufacturer that the device is not repairable
- Intermittently operational and has required numerous repairs, include documentation from the manufacturer outlining the history of repairs on the device (include dates, costs and a summary how damages were sustained)

Device Accessories and Software

Justification for accessories and software programs must be included.

Treatment Plan and Follow-up Training

Communication Goals	Therapist/Facility/Agency	Time Line

Treating SLP must be involved with the development of this treatment plan. Evaluating SLP must develop, in coordination with the recipient, caregiver(s) and treating SLP (e.g., school, day program, LTC) a basic vocabulary to be provided to the augmentative communication provider for initial setup of the device.

SIGNATURE OF EQUIPMENT SPECIALIST	DATE
SIGNATURE OF SLP INVOLVED IN EVALUATION AND CREDENTIALS	DATE
SIGNATURE OF PHYSICIAN VERIFYING INFORMATION	DATE