Speech Language Pathologist (SLP) Evaluation for Speech Generating Devices (SGD)

Washington State Health Care Authority

Health Care Authority (HCA) Authorization Services Office
PO Box 45535 Olympia, WA 98504-5535
Fax: (866) 668-1214

Please provide the information below. Print or type your answers, attach the required supporting documentation, sign date, and submit the request as follows:

1. **Online submission:** Complete an online submission via the ProviderOne Portal. Submit the HCA prescription form 13-794, this completed form online along with supporting documentation.
2. **Written submission:** Fax a completed General Information for Authorization form (13-835), as the first page of the fax, the HCA prescription form (13-794), this completed form and supporting documentation to the Authorization Services Office at 1-866-668-1214. Please do not send fax cover sheet with request.

Section I General information

Client name

Client ProviderOne ID

Supplier's name

Supplier

Supplier's phone number

Supplier fax number (with area code)

Evaluating Speech Language Pathologist's (SLP) name

Evaluating SLP phone number (with area code)

Evaluating SLP fax number (with area code)

Speech generating device (SGD), mounting device and accessories requested (include HCPCS code):

Section II Background information

Speech and Language Diagnosis

ICD-10

Description

ICD-10

Description

Specific communication needs as it relates to environmental, medical, and daily living:

Client Device Access:

Use Keyguard: ☐ with hand ☐ without hands

Alternative access: ☐ switch ☐ joystick ☐ eye gaze ☐ head pointing

Other.

Does the client currently own an SGD? ☐ Yes ☐ No

If yes, name and model of device: _____ Serial number: _____

Purchased by: _____ HCA _____ Other insurance _____

Other/Unknown: _____ Date device purchased or approximate age of device: _____

Explain why the current device no longer meets the client's needs:

☐ Device outdated or no longer supported by manufacturer ☐ Device non-functional

☐ Change in client condition

Explain: _____

Current Hearing Status:

Within functional limits with best correction? ☐ Yes ☐ No

Does hearing status influence the client's communication and/or the SGD choice? ☐ Yes ☐ No

Explain: _____

Current Vision Status:

Within functional limits with best correction? ☐ Yes ☐ No

Does vision status influence the client's communication and/or the SGD choice? ☐ Yes ☐ No

Enrolled in school: ☐ Yes ☐ No **Employed:** ☐ Yes ☐ No

Comments:

Section III Speech and Lanuage Status

Evaluation by Speech and Language Pathologist

Cognition Assessment: Describe the client's abilities and/or deficits in each of the following areas as they relate to the ability to use an SGD and accessories.

1. Attention Skills: _____

2. Memory: _____

3. Problem Solving: _____

Comments

Current Receptive Language Abilities:

Demonstrates the ability to comprehend: ☐ Phrases ☐ Gestures/signs ☐ Photos

☐ Symbols ☐ Sentences ☐ Conversations ☐ Written words

Describe ability to follow commands:

Describe comprehension of yes/no questions related to functional choices and number of choices offered:

Comments:

Current Expressive Language Abilities:

Demonstrates the ability to comprehend: ☐ SGD ☐ Vocalizations ☐ Verbalizations

☐ Sign Language ☐ Gestures ☐ Writing ☐ Spelling ☐ Photos ☐ Symbols

☐ Other: _____

Current social communication abilities:

Identify current communication partners: _____

Identify current communication purposes: _____

Comments:

Describe the client's speech and language therapy history as it relates to augmentative and alternative communication:

Is it anticipated that the client would obtain functional speech to communicate medically necessary? ☐ Yes ☐ No

Comments:

Section IV Motor/Postural/Mobility Status

Functional Ambulation/Mobility/Motor Function

Ambulation: ☐ Independent (no ambulation/mobility aids)

☐ Modified independent with aid. List the ambulation/mobility aids used: _____

☐ Manual Wheelchair (MWC) ☐ Power Wheelchair (PWC)

☐ Is integration with PWC required? Please explain: _____

Describe how the client will physically access an SGD? _____

Comments

Section V Rationale for Recommended Device, Mount and Accessories

List all devices considered or trialed and observations. Describe your observation of the client's use of each device and medical justification for the device selected. Describe rationale for why devices considered or trialed were ruled out or not selected.

Section VI Treatment Plan and Goals

Communication Goals:

What are the initial short-term goals?

What are the initial long-term goals?

How will the recommended device be supported?

Section VII Evaluating SLP signature

Note: This section will only be completed by SLP providers

SLP signature

Date