Idaho Medicaid SGD Supplemental Form

Please complete entire form and submit with DME Prior Authorization Form

Date of Evaluation:

Medicaid Participant Information	
Last Name:	First Name:
Medicaid ID:	Date of Birth:
Speech-Language Diagnosis & ICD Codes:	Date of Onset:
Anticipated Course of Impairment:	

Speech-Language Pathologist Information	
Provider Name:	NPI:
Phone:	Fax:

Summary of Current Skills
Summarize Development and Speech/Language Skills: (Attach ST Communication Evaluation. Include inventory of communication skills and sensory function.)
Current Communication Impairment: ☐ Mild ☐ Moderate ☐ Severe
Summarize: *If additional room is needed please use a separate piece of paper*
Physical, Cognitive, Hearing, and Vision Abilities and How They Affect the Use of the Requested Device:
Summarize: *If additional room is needed please use a separate piece of paper*

Has Pt Had or Does Pt Have an SGD? ☐ Yes ☐ No	Date of Purchase:	Length of Use:
Current/Previous SGD Make & Model:	☐ Aided ☐ Unaided ☐ Low-Tech ☐ High-Tech	
Any Issues with the Current/Previous SGD: ☐ Yes ☐ No Explain: *If additional room is needed please use a separate piece of paper*		

Phone: (866) 205-7403

More information is available at **www.dme.Idaho.gov** and **www.idmedicaid.com**

Functional Benefit of Upgrade **OR** State "No SGD in the past": *If additional room is needed please use a separate piece of paper*

Functional communication goals:

☐ Gain attention of familiar & unfamiliar communication partners
☐ Provide personal info to communication partners
☐ Request personal ADL assistance
☐ Other: *If additional room is needed please use a separate piece of paper*
☐ Ask questions
☐ Participate in medical appointments
☐ Request food, drink, object or action

Why are you requesting an SGD?

☐ Participant's speaking needs cannot be met using natural communication methods or low-technology speaking devices.

Participant needs the ability to:

☐ Express thoughts and ideas in emergency situations
☐ Report to medical staff pain or other medical needs
☐ Request object or actions
☐ Other: *If additional room is needed please use a separate piece of paper*
☐ Verbalize physical wants and needs to caregivers and family
☐ Communicate with peers, family and others

What are the anticipated needs to warrant an SGD?

☐ Ability to communicate physical needs and wants
☐ Socialize with family and caregivers
☐ Other: *If additional room is needed please use a separate piece of paper*
☐ Communicate with medical and educational staff
☐ Improve expressive language

What features are needed or requested by this client/caregivers and justification for features? *If additional room is needed please use a separate piece of paper*

Trial Information				
Trial documentation must include: ☐ Minimum of three SGD trials from at least two different vendors. ☐ Trial length of 1 week to 1 month for each device that may meet participant's communication needs. ☐ The amount of time the participant used the device each week.				
Device Trialed:				
Date Trial Started:		Duration of Trial:		
Direct Select:	☐ Eyes	☐ Touch	☐ Other:	
Scanning:	☐ One Switch	☐ Two Switch	☐ Auditory	☐ Visual
Summary: *If additional room is needed please use a separate piece of paper*				
Device Trialed:				
Date Trial Started:		Duration of Trial:		
Direct Select:	☐ Eyes	☐ Touch	☐ Other:	
Scanning:	☐ One Switch	☐ Two Switch	☐ Auditory	☐ Visual
Summary: *If additional room is needed please use a separate piece of paper*				
Device Trialed:				
Date Trial Started:		Duration of Trial:		
Direct Select:	☐ Eyes	☐ Touch	☐ Other:	
Scanning:	☐ One Switch	☐ Two Switch	☐ Auditory	☐ Visual
Summary: *If additional room is needed please use a separate piece of paper*				

SGD Recommendation

SGD Brand:	
Model Name:	Model Number:
☐ The participant's ability to meet daily communication needs will greatly benefit from acquisition & use of the device.	
Software Recommended:	
Accessories/Mounting:	
This combination of hardware, accessories, and software meets the communication needs of the participant because:	

Support Team

Please, list support team names and numbers (i.e. special education teacher, physical therapist, occupational therapist, school/private speech-language pathologist, habilitative interventionist, etc.).

Name of Team Member & Role	Phone Number

Who is responsible for programming, updating, and maintenance of the device?
How has the Pt's IEP team, caregiver, physician, or other communication partners been included in this evaluation process?
☐ A copy of this report has been forwarded to the participants treating Physician prior to ordering device

Additional Required Documentation

☐ Current speech/language reports including plan of care.
☐ If applicable: Current Individualized Education Program (IEP).
☐ If applicable: Letters documenting medical necessity.

Acknowledgement

By signing below, I agree that I am not an employee of, or have a financial relationship, with any assisted technology/speech generating device manufacturer. I agree to the information and recommendations in this report.

Speech-Language Pathologist's Signature	Phone Number	Date
Physician's Signature	Phone Number	Date

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REV 04/2019