NEW HAMPSHIRE MEDICAID

AUGMENTATIVE AND ALTERNATIVE COMMUNICATION (AAC) AIDS FUNDING INFORMATION

NH Medicaid covers augmentative and alternative communication (AAC) aids when they are medically necessary and when they meet standard clinical practice criteria. Examples of covered equipment include: communication devices, mounts, access peripherals/switches, symbol sets/overlays, cases, straps, carrying devices, repairs, rentals, and purchases.

INSTRUCTIONS FOR GETTING AN AAC AID COVERED THROUGH NH MEDICAID

1. **Contact Medicaid Medical Services** (noted below) to learn more, and to get help with this process.
2. **Meet with a Speech Language Pathologist (SLP)** to complete an AAC evaluation, and to complete and sign this form.
3. **Ask your doctor** to prescribe the AAC aid recommended in the AAC evaluation, and to write a letter of medical necessity, if needed.
4. **Send the following to an AAC provider:**
   - ❑ This completed form (AAC Aids Funding Information form)
   - ❑ A copy of the recipient's Medicaid ID card
   - ❑ A completed AAC Evaluation Report (see #2 above)
   - ❑ A prescription from the recipient's doctor (see #3 above)
   - ❑ A completed Trial Summary form (if applicable)
   - ❑ A completed Safeguarding Plan (if applicable)
5. **If you need help finding a AAC provider, contact Medicaid Medical Services noted below.**

   The AAC provider will submit a request to the NH Department of Health and Human Services on your behalf. If the request is approved, the AAC provider will process your order, and ship the equipment to you.

WHO TO CONTACT FOR HELP

Medicaid Medical Services
129 Pleasant St., Concord NH 03301
Fax: (603) 314-8101
Email: ServiceAuthorizationFFS@dhhs.nh.gov

Recipient Name:_____
Date Completed:_____

CONTACT INFORMATION Provide contact information for the following individuals		
	Name/Address	**Phone/Fax/email**
The Recipient		
Parents/guardians (if applicable)		
Speech Language Pathologist (SLP) - the SLP that works closest with the recipient	☐ Check here if "none"	
AAC Consultant - the SLP who conducted the AAC evaluation	☐ Check here if "same as above"	
Primary Care Physician (PCP) - the doctor the recipient sees most often		
A person familiar with the recipient's AAC needs, and who will support the recipient's use of the AAC aid		
Any other individual involved in the AAC evaluation		

RECIPIENT INFORMATION Provide the following information about the Medicaid recipient who is requesting the AAC aid		
NH Medicaid ID Number:	**Gender:**	**Date of Birth:**
	☐ Male ☐ Female	
Primary Diagnosis:		
Speech Diagnosis:		
Type of Residence:	☐ Home ☐ Nursing home ☐ Group home ☐ Family assistive living ☐ Residential school	
Prognosis for unassisted communication:	☐ Good ☐ Fair ☐ Guarded ☐ Poor	

Recipient Name:_____
Date Completed:_____

PRIVATE INSURANCE/MEDICARE BILLING INFORMATION Complete this section only if the Medicaid recipient has private insurance in addition to Medicaid	
Name, address, and phone number of the insurance carrier:	
Name, address, and date of birth of the person holding the policy	
Policy and group numbers of the policy holder	

REQUESTED EQUIPMENT Provide detailed information about the AAC aid being requested			
Item/Part#	**Product Description**	**Price**	**# of months (rental only)**

DELIVERY INFORMATION Provide information as to where the AAC aid will be sent	
Name/Attention to:	
Physical/Street Address:	**(cannot be a PO Box)**
Phone number:	

Recipient Name:_____
Date Completed:_____

TO BE COMPLETED BY THE AAC CONSULTANT WHO COMPLETED THE AAC EVALUATION

AAC USER PROFILE Briefly describe the recipient's communication abilities in the following areas	
Physical Access:	
Vision:	
Hearing:	
Cognitive Level:	
Receptive Language:	
Expressive Language:	

REFERRING PERSON
Who referred the recipient to you?

☐ SLP ☐ Family Member ☐ Case Manager ☐ Educator ☐ Employer

☐ Physician ☐ Nursing Home ☐ Rehabilitation Center ☐ Early Intervention Provider

☐ Other_____

AAC CONSULTANT SIGNATURE

AAC Consultant Printed Name:_____

AAC Consultant Signature:_____