**DEPARTMENT OF VERMONT HEALTH ACCESS**

**EVALUATION FOR A SPEECH GENERATING DEVICE (SGD)**

**APPLICATION DATE**

|  |  |
| --- | --- |
| Date of Application |  |

**MEMBER INFORMATION**

|  |  |
| --- | --- |
| Name |  |
| Medicaid Unique ID |  |
| Date of Birth |  |

**PRIMARY CARE PROVIDER INFORMATION (PHYSICIAN, PHYSICIAN ASSISTANT, NURSE PRACTITIONER)**

|  |  |
| --- | --- |
| Name |  |
| Medicaid Provider # |  |

**DURABLE MEDICAL EQUIPMENT (DME) PROVIDER**

|  |  |  |
| --- | --- | --- |
| Name |  |  |
| Medicaid Provider # |  |  |

**REQUESTED CODES**

|  |  |  |
| --- | --- | --- |
| SGD Procedure Codes | E2510 iPad/SGD | E2511 application |
| E2512 mounts | E2599 accessories |

**FUNDING INFORMATION**

|  |  |  |
| --- | --- | --- |
| Other Insurance |  | Client **does not** have any other insurance – skip next box |
|  | Client **does have** other insurance - complete Insurance policy entry below |
| Insurance Policy (to be supplied to DVHA by the Durable Medical Equipment (DME) Provider) |  | Attached - Copy of **insurance policy or denial letter** related to SGDs including not covered, covered partially, or covered fully, and any iPad restrictions |

**SPEECH LANGUAGE PATHOLOGIST (SLP) INFORMATION**

|  |  |
| --- | --- |
| Prescribing SLP |  |
| SLP Contact Info |  |
| Augmentative and Alternative Communication (AAC) Consultant (optional) |  |

**DIAGNOSIS CODE INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| Medical Diagnosis: the underlying condition |  | ICD10 diagnosis code |  |
| Communication Diagnosis |  | ICD10 diagnosis code |  |

**SGD EVALUATION REPORT**

SGD EVAL INSTRUCTIONS

|  |
| --- |
| Sources of information for this eval include: Referring provider, DME provider, medical and school team, family, individualized education program (IEP), outside evaluations, trial planning forms, trial data forms. All sections must be filled out by the prescribing SLP unless otherwise noted.  This communication device evaluation should do the following:   * Establish a current picture of the member from a medical perspective * Promote care coordination between individual service providers, family members/guardians, and medical personnel * Promote high expectations for the person’s capacity to learn and use a communication device * Encourage a thoughtful process of selecting the most appropriate hardware and software * Model appropriate AAC program practices that will continue after procurement of the device * Firmly establish the medical necessity of the speech generating device for the member |

**MEMBER PROFILE**

|  |  |
| --- | --- |
| Communication History |  |
| In the sections below, document important information about the member’s current abilities and challenges for each area. For children with IEPs: access the ‘present levels’ section of the IEP for information. | |
| Home |  |
| Health/Medical |  |
| Vision/Hearing |  |
| Physical/Mobility |  |
| Fine Motor |  |
| Activities of Daily Living |  |
| Cognition / Literacy /Learning |  |
| Social-Emotional |  |
| Speech /Language / Communication |  |
| Other |  |

**TRIAL PREPARATION**

|  |  |
| --- | --- |
| Dates of Trial (must be at least one month) | Start       End |
| Trial Participants |  |
| Trial Contexts (must include a robust home component) |  |
| Data Collection System |  |

**TRIAL PROCESS**

|  |  |
| --- | --- |
| Overview of Trial/ Consideration of SGDs |  |
| Trial Description |  |
| Trial Performance Data | *Use Baseline - Endline data chart below and any other hard data to support the medical necessity of the request.* |

**TRIAL RESULTS**

|  |  |  |
| --- | --- | --- |
| Recommended SGD and Accessories |  | |
| Technology Selection | *As a result of the device consideration process, the team has determined:* | |
|  |  | that a Mobile Communication Device - commercially available technology, such as iPad - is appropriate for the individual OR |
|  | that a Specialized Communication Device – a device specifically designed for augmentative communication and available through specialized vendors, such as a traditional speech generating device - is required for the individual. |
| Specialized Device Evidence | *Consideration of assistive technology requires identification of the most cost-effective tool to meet the individual’s needs. Please provide specific, compelling evidence that demonstrates that the member could not use a Mobile Communication Device and instead requires a Specialized Communication Device. Address motor / physical access, sensory access, and durability issues as appropriate.* | |
| Features of Recommended SGD |  | |
| Features of Recommended Accessories |  | |
| Rationale for SGDs Not Selected |  | |

**SGD PLAN**

|  |  |
| --- | --- |
| Plan for successful receipt and use of the device. | |
| SGD Shipping Contact |  |
| For Apple devices only: Apple ID Information (optional) | *Creation of a NEW Apple ID for the member is recommended to prevent privacy issues and prevent the ability to access unwanted apps. Be sure to follow Apple’s ID guidelines for children under age 13*. |
| SGD Preparation Plan |  |
| Functional Communication Goals |  |
| Treatment Plan | *Plan for speech language pathology treatment after receipt of the device* |
| Training Plan | *Training must include family/guardians and other professionals/ paraprofessionals that will be communicating with the member* |
| Care Coordination Plan | *Specify if there are home/ community based SLP services AND school based SLP services. Document the plan to ensure care coordination* |
| Device Care Plan | *Identify the person(s) who will be responsible for ensuring that the device is transported, used, and stored* ***safely*** *and receives necessary* ***maintenance, and the plan for safe transport of the device*.** |
| Analysis | *Team’s conclusions from the trial process* |

**BASELINE/ENDLINE DATA CHART**

DATA CHART INSTRUCTIONS

|  |
| --- |
| *Communication device skills and abilities are listed in the chart below from basic to complex.*  *Check off 0, 1 or 2 for each behavior statement at the start of the trial (first 3 columns) and repeat at the end of the trial (last 3 columns).*  *In the last section of the chart, indicate which language functions were demonstrated at the start of the trial as compared to the end.* |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Member Name |  | | | | | | | |
| Trial Start Date |  | | | Trial End Date | | |  | |
| Device/Application |  | | | | | | | |
| Rating Scale | 0 | Never, rarely | 1 | | Sometimes, inconsistently | 2 | | Consistently |

| **Start Trial Rating** | | |  | **End Trial Rating** | | |
| --- | --- | --- | --- | --- | --- | --- |
| **0** | **1** | **2** | **0** | **1** | **2** |
| **Observable Behavior** | | | | | | |
| **Device Awareness / Acceptance** | | | | | | |
|  |  |  | permits device in personal space |  |  |  |
|  |  |  | permits partner to use device in personal space |  |  |  |
|  |  |  | looks towards device |  |  |  |
|  |  |  | attends to partner using device |  |  |  |
|  |  |  | attends to device display |  |  |  |
|  |  |  |  |  |  |  |
| **Early – Emergent Independent Access** | | | | | | |
|  |  |  | reaches for display |  |  |  |
|  |  |  | explores targets |  |  |  |
|  |  |  | explores targets intentionally |  |  |  |
|  |  |  | activates targets following model (imitation) |  |  |  |
|  |  |  | reaches for display at appropriate time in interaction (accuracy not considered) |  |  |  |
|  |  |  | reaches for/towards specific target |  |  |  |
|  |  |  | navigates to word not on current screen |  |  |  |
|  |  |  | remembers navigation to familiar message (in same session) |  |  |  |
|  |  |  | remembers navigation to familiar message (not in same session) |  |  |  |
|  |  |  | Uses single word for a variety of communicative functions |  |  |  |
|  |  |  | Uses a variety of vocabulary / parts of speech |  |  |  |
| **Advanced Independent Access** | | | | | | |
|  |  |  | sequences icons to produce single word/message (no navigation) |  |  |  |
|  |  |  | sequences icons to produce multi-word (2 or more words) phrase/sentence (no navigation) |  |  |  |
|  |  |  | locates word within categories |  |  |  |
|  |  |  | produces 2-word phrase |  |  |  |
|  |  |  | produces 3-word phrase |  |  |  |
|  |  |  | produces 4 / 4+ word phrases |  |  |  |
|  |  |  | repairs errors in navigation |  |  |  |
|  |  |  | uses word endings |  |  |  |
| **Application Operations** | | | | | | |
|  |  |  | activates message window to speak message |  |  |  |
|  |  |  | uses “clear” (display) function |  |  |  |
|  |  |  | uses “delete” (letter, word) function |  |  |  |
|  |  |  | uses “home” button to return to main screen |  |  |  |
|  |  |  | Shows ownership of device |  |  |  |
| **Text-Based Skills** | | | | | | |
|  |  |  | uses app keyboard |  |  |  |
|  |  |  | uses keyboard word prediction |  |  |  |
|  |  |  | uses search feature |  |  |  |
|  |  |  | Uses history feature |  |  |  |
|  |  |  | Total Items Per Rating |  |  |  |
|  |  |  | **Totals Per Rating** |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| **Language Functions Observed** | | | | | | |
|  |  |  | Request |  |  |  |
|  |  |  | Greet |  |  |  |
|  |  |  | Refuse / Reject / Protest |  |  |  |
|  |  |  | Comment |  |  |  |
|  |  |  | Ask Questions |  |  |  |
|  |  |  | Share Information |  |  |  |
|  |  |  | Repair communication |  |  |  |

**PRESCRIPTION FORM**

PRESCRIPTION FORM INSTRUCTIONS

This form is a prescription for speech generating devices and accessories. Provide specific Information about the member, providers (doctor/PA-C, nurse practitioner, SLP, vendor) and their contact information, and prescribed items. Signatures from the member (or legal guardian), ordering provider, and SLP are required.

**MEMBER INFORMATION**

|  |  |
| --- | --- |
| Member’s name |  |
| Address |  |
| Member’s Medicaid ID # |  |
| Member’s Email Address |  |
| Member’s Apple ID (optional) |  |
| Member’s Primary (underlying condition) Diagnosis Code |  |

**PRESCRIBED DEVICE, APPLICATION, AND PERIPHERALS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Item** | **Specific Name** | **Vendor** | **Item #** | **Link** |
| E2510 SGD |  |  |  |  |
| E2511 app |  |  |  |  |
| E2512 mount |  |  |  |  |
| E2599 other components |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**PRESCRIPTION SIGNATURES**

|  |  |  |
| --- | --- | --- |
| I acknowledge that this device is medically necessary and is provided for use as the sole dedicated speech-generating device for this member. The purpose of the device provided is for communication that originates from the member and not a facilitator or support person, and the device must be used as determined by the prescribing speech language pathologist to ensure the safety and maximum benefit of the member. All parties signed below deem this prescription accurate and medically appropriate: | | |
| Member or legal guardian | Printed Name |  |
| Signature |  |
| Date |  |
| Contact Information |  |
| Primary care physician/ PA-C/nurse practitioner | Printed Name |  |
| Signature |  |
| Date |  |
| Contact Information |  |
| Speech Language Pathologist | Printed Name |  |
| Signature |  |
| Date |  |
| Contact Information |  |

**MEDICAL NECESSITY**

|  |  |
| --- | --- |
| Medical Necessity | Check all statements below that are true and demonstrate medical necessity: |
| Member requires speech-language pathology treatment |
| Member is unable to meet their daily communication needs using natural communication methods |
| Speech-generating device is recognized in current, peer reviewed medical literature as an appropriate treatment for Member’s communication impairment diagnosis. |
| Member’s receptive language is or appears higher than their expressive language |
| Member’s ability to report medical needs, including but not limited to activities of daily living, communicate with medical personnel, share important personal information, is impacted by a speech impairment. |

**DME OWNERSHIP, OPERATION, AND MAINTENANCE AGREEMENT**

DME AGREEMENT INSTRUCTIONS

Provider and member/legal guardian must sign this sheet and provide it to the DVHA for review. The provider must keep this form on file and provide a copy to the member for their records. If Vermont Medicaid is providing primary coverage for the device, a Vermont Medicaid sticker must be affixed to the device upon delivery of the equipment. Do not apply a sticker or sign this form if the device will be covered by a primary insurance.

Your checkmark or initials, and your signature at the bottom of the form indicate agreement with each statement.

**Speech Language Pathologist Acknowledgement** (please check each statement if accurate):

I have researched, and have not found, any less costly devices that would be appropriate to the member’s medical needs at this time. Any components from the member’s current equipment that can be utilized will be placed on the new device.

I have instructed the member/guardians on the safe use of the device.

I have explained to the member/guardians that, should the device no longer meet the medical need or be needed by the member, it is the property of Vermont Medicaid and should be returned to Vermont Medicaid; please call the number on the sticker placed on the equipment by the provider.

I have explained to the member/guardians that the expectation is that this device will last for at least 5 years and should be treated so that it will last for this amount of time. If there is a change in the member’s condition, consideration will be given to replacing the device/accessories.

I have explained to the member/guardians that, should any defects in the device develop, the member/guardians should report the defects to the vendor.

I have explained to the member/guardians that, should the device be lost or stolen, a police report must be submitted with any request for replacement of the device.

**Member / Legal Guardian Acknowledgement** (please check each statement if accurate):

I accept the specific device and/or components that have been requested on my/the member’s behalf by the prescribing medical professional.

I have had an opportunity to try the device or a simulation so that I know it will work for me/the member.

I understand how to properly care for and maintain the device so that it can last for 5 years.

I understand how to properly operate the device.

I understand that to return the device, I should call the number on the sticker that has been placed on the device.

I understand that if the device is lost or stolen, a police report must be submitted with any request for a replacement of this device

Speech language pathologist’s signature

Click or tap here to enter text.

Member / legal guardian signature:

Date: Click or tap to enter a date.

Date:

|  |  |  |  |
| --- | --- | --- | --- |
| **SLP Signature** |  | **Date** |  |
| **Member Signature** |  | **Date** |  |