Iowa Department of Human Services

AUGMENTATIVE COMMUNICATION SYSTEM SELECTION

IMPORTANT: This information must be submitted to Medicare within six months of the evaluation.

Recipient Name	**Medicaid Number**	**Date of Birth**	
Address	**City**	**State**	**Zip**

Section A To be completed by physician. Use additional sheets as needed.

Medical diagnosis and history:

Medical prognosis:

Physician Signature	**Name**
Address	**Phone**

Section B To be completed by speech or language pathologist. Use additional sheets as needed.
Please describe current functional abilities in terms of:

Communication Skills:

Motor Status:

Sensory Status:

Cognitive Status:

Social/emotional Status:

Language Status:

Information is also needed on the following:

Educational ability and needs:

Anticipated duration of need:

Prognosis regarding oral communication skills:

Prognosis with a particular device: (Has there been a trial period with this or a similar device?)

Recommendation: (Why this particular device? What other kinds of equipment have been used?)

Speech or Language Pathologist Signature	**Name**
Address	**Phone**

Section C To be completed by consultant or fiscal agent.

Language skills:

Communication System

☐ Approved

☐ Denied

Type

Reason

Signature