Idaho Medicaid Speech Generating Device (SGD) Evaluation

This completed form must be attached to all Speech Generating Device prior authorization (PA) requests. All information from the general prior authorization form can be entered when submitting the request via online portal (http://myqualitrac.com). If choosing to submit the request via fax: Fax this completed form, a completed general PA form, all required documentation, and documentation of medical necessity to (866) 539-0365.

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:		
Physical, Cognitive, Hearing, and Vision Abilities and How They Affect the Use of the Requested Device:		
Summarize:		
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:

Functional Benefit of Upgrade **OR** State "No SGD in the past":

Functional communication goals:

☐ Gain attention of familiar & unfamiliar communication partners
☐ Ask questions
☐ Provide personal info to communication partners
☐ Participate in medical appointments
☐ Request personal ADL assistance
☐ Request food, drink, object or action
☐ Other:

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
☐ Verbalize physical wants and needs to caregivers and family
☐ Report to medical staff pain or other medical needs
☐ Communicate with peers, family and others
☐ Request object or actions
☐ Other:

What are the anticipated needs to warrant an SGD?

☐ Ability to communicate physical needs and wants
☐ Communicate with medical and educational staff
☐ Socialize with family and caregivers
☐ Improve expressive language
☐ Participant is nonverbal and does not use speech to communicate. Traditional speech therapy techniques have been unsuccessful. Is unable to convey the type and complexity of information she/he is capable of communicating in daily interactions without a speech generating device.
☒ Other:

What features are needed or requested by this client/caregivers and justification for features?

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:				
Device Trialed:				
Date Trial Started:		Duration of Trial:		
Direct Select:	☐ Eyes	☐ Touch	☐ Other:	
Scanning:	☐ One Switch	☐ Two Switch	☐ Auditory	☐ Visual

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Summary:				
Device Trialed:				
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Direct Select:	☐ Eyes	☐ Touch	☐ Other:	
Scanning:	☐ One Switch	☐ Two Switch	☐ Auditory	☐ Visual
Summary:				

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 patient'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, the Speech/Language Pathologist performing this evaluation is not an employee of and does not have a financial relationship with the supplier of the speech generating device.

I agree to the information and recommendations in this report.

____

Speech-Language Pathologist's Signature   Phone Number   Date

____

Physician or Non-Physician Practitioner's Signature   Phone Number   Date

- *The status of a prior authorization request may be checked via portal or by calling (866) 538-9510.*
- *Any questions regarding this process may be sent to IDMedicaidsupport@telligen.com.*
- *More information is available at idmedicaid.com*