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HEALTH SYSTEMS DIVISION
Provider Clinical Support

Oregon Health Authority

Augmentative Communication Device Selection Report Summary

Complete and submit this form with documents listed in Oregon Administrative Rule 410-129-0220 and a Formal Augmentative/Alternative Communication Evaluation that includes:

- History and background,
- Communication needs: Partners, locations, positions, modes, and topics,
- Communication abilities, including past and present means of communication,
- Language skills across all modalities,
- Communication devices considered, with a detailed explanation of their features and any related software,
- An explanation of why the device is medically necessary to communicate basic needs and medical information, and why the device selected is the lowest level of equipment that meets the medical need,
- Recommendations, and
- Plan of care: Who will provide device training and follow-up care.

Note:

- All fields must be completed
- Attach only pertinent clinical documentation

Client information

Client name: ______________________ Request date: __________

Medicaid ID: ______________________ Date of birth: __________

Contact information

Provider name: ______________________ Phone number: __________

Provider discipline or specialty: ______________________

Ordering provider name: ______________________ Phone number: __________

Ordering provider discipline or specialty: ______________________

Submitted by: ______________________ Phone number: __________

Device information

Item: ______________________ Estimated cost: __________

Manufacturer: ______________________ Duration of need: __________

Distributor/dealer: ______________________

This request is for:

☐ New:

How will this device meet the client's communication needs?

Comparison of three different like items of least costly options:

1) Type: ______________________ Cost: ______________

Why will this not meet the client's needs?

2) Type: ______________________ Cost: ______________

Why will this not meet the client's needs?

3) Type: ______________________ Cost: ______________

Why will this not meet the client's needs?

☐ Replacement:

Type of the current device: ______________ Date of purchase: ______________

Why is this device no longer able to meet the client's communication needs?

Is the replacement due to damage to the current device? ☐ Yes ☐ No

Please explain: ______________________________

Cost to repair the device: ______________ Cost of replacing the device: ______________

☐ Repairs:

Type of the current device: ______________ Date of purchase: ______________

What needs to be repaired and why is this device no longer able to meet the client's communication needs?

Is the repair due to damage to the current device? ☐ Yes ☐ No

Cost to repair the device: ______________ Cost of replacing the device: ______________

If approved, where should the device be shipped?

Rationale for selecting this specific device:

How you will know that this device will be successful?

What means of communication will this device replace? Describe patient's current means:

Clinical information

Medical diagnosis: ____________________

Speech-language diagnosis: ________________

Medical prognosis: ____________________

General medical status: ________________

Respiratory: ____________________

Head control: ________________

Hearing: ____________________

Trunk stability: ________________

Vision: ____________________

Arm movement: ________________

Ambulation: ____________________

Seating/position for use of device: ________________

Social/emotional: ____________________

Ability to access device: ________________

Communication abilities – *Check all that apply.*

- ☐ Attempts to communicate with consistent response
- ☐ Is able to make choices
- ☐ Understands that communication will cause an action to occur
- ☐ Understands that symbols stand for verbal communication
- ☐ Prognosis to develop intelligible speech:
- ☐ Prognosis for communication ability:
- ☐ Necessary supports to be successful (*e.g.,* caregiver, family, professionals):