

Speech Language Pathologist (SLP) Evaluation for Speech Generating Devices (SGD)

Health Care Authority (HCA) Authorization Services Office
PO Box 45535 Olympia, WA 98504-5535
Fax: (866) 668-1214

Please provide the information below. Print or type your answers, attach the required supporting documentation, sign date, and submit the request as follows:

- 1. Online submission:** Complete an online submission via the ProviderOne Portal. Submit the HCA prescription form 13-794, this completed form online along with supporting documentation.
- 2. Written submission:** Fax a completed General Information for Authorization form (13-835), as the first page of the fax, the HCA prescription form (13-794), this completed form and supporting documentation to the Authorization Services Office at 1-866-668-1214. Please do not send fax cover sheet with request.

Section I

General information

Client name	Client ProviderOne ID
Supplier's name	Supplier
Supplier's phone number	Supplier fax number (with area code)
Evaluating Speech Language Pathologist's (SLP) name	
Evaluating SLP phone number (with area code)	Evaluating SLP fax number (with area code)

Speech generating device (SGD), mounting device and accessories requested (include HCPCS code):

Section II

Background information

Speech and Language Diagnosis

ICD-10	Description
ICD-10	Description

Specific communication needs as it relates to environmental, medical, and daily living:

Client Device Access:

Use Keyguard: with hand without hands
Alternative access: switch joystick eye gaze head pointing

Other:

Does the client currently own an SGD? Yes No

If yes, name and model of device: Serial number:

Purchased by: HCA Other insurance

Other/Unknown: Date device purchased or approximate age of device:

Explain why the current device no longer meets the client’s needs:

Device outdated or no longer supported by manufacturer Device non-functional
Change in client condition

Explain:

Current Hearing Status:

Within functional limits with best correction? Yes No
Does hearing status influence the client’s communication and/or the SGD choice? Yes No

Explain:

Current Vision Status:

Within functional limits with best correction? Yes No
Does vision status influence the client’s communication and/or the SGD choice? Yes No

Enrolled in school: Yes No **Employed:** Yes No

Comments:

Evaluation by Speech and Language Pathologist

Cognition Assessment: Describe the client’s abilities and/or deficits in each of the following areas as they relate to the ability to use an SGD and accessories.

- 1. Attention Skills:
- 2. Memory:
- 3. Problem Solving:

Comments

Current Receptive Language Abilities:

Demonstrates the ability to comprehend:

Phrases	Gestures/signs	Photos
Symbols	Sentences	Conversations
		Written words

Describe ability to follow commands:

Describe comprehension of yes/no questions related to functional choices and number of choices offered:

Comments:

Current Expressive Language Abilities:

Demonstrates the ability to comprehend:

SGD	Vocalizations	Verbalizations
Sign Language	Gestures	Writing
		Spelling
		Photos
		Symbols

Other:

Current social communication abilities:

Identify current communication partners:

Identify current communication purposes:

Comments:

Describe the client's speech and language therapy history as it relates to augmentative and alternative communication:

Is it anticipated that the client would obtain functional speech to communicate medically necessary? Yes No

Comments:

Section IV

Motor/Postural/Mobility Status

Functional Ambulation/Mobility/Motor Function

Ambulation: Independent (no ambulation/mobility aids)

Modified independent with aid. List the ambulation/mobility aids used:

Manual Wheelchair (MWC) Power Wheelchair (PWC)

Is integration with PWC required? Please explain:

Describe how the client will physically access an SGD?

Comments

Section V

Rationale for Recommended Device, Mount and Accessories

List all devices considered or trialed and observations. Describe your observation of the client's use of each device and medical justification for the device selected. Describe rationale for why devices considered or trialed were ruled out or not selected.

Section VI

Treatment Plan and Goals

Communication Goals:

What are the initial short-term goals?

What are the initial long-term goals?

How will the recommended device be supported?

Section VII

Evaluating SLP signature

Note: This section will only be completed by SLP providers

SLP signature

Date