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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):