Idaho Medicaid SGD Supplemental Form

Please complete entire form and submit with DME Prior Authorization Form

Date of Evaluation:

<table>
<thead>
<tr>
<th>Medicaid Participant Information</th>
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<tbody>
<tr>
<td>Last Name:</td>
<td>First Name:</td>
</tr>
<tr>
<td>Medicaid ID:</td>
<td>Date of Birth:</td>
</tr>
<tr>
<td>Speech-Language Diagnosis &amp; ICD Codes:</td>
<td>Date of Onset:</td>
</tr>
<tr>
<td>Anticipated Course of Impairment:</td>
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<tr>
<th>Speech-Language Pathologist Information</th>
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<tbody>
<tr>
<td>Provider Name:</td>
<td>NPI:</td>
</tr>
<tr>
<td>Phone:</td>
<td>Fax:</td>
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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: If additional room is needed please use a separate piece of paper

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

Summarize: If additional room is needed please use a separate piece of paper

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: If additional room is needed please use a separate piece of paper

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Phone: (866) 205-7403
More information is available at www.dme.idaho.gov and www.idmedicaid.com

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Functional Benefit of Upgrade OR State “No SGD in the past”: If additional room is needed please use a separate piece of paper

Functional communication goals:

- Gain attention of familiar & unfamiliar communication partners
- Provide personal info to communication partners
- Request personal ADL assistance
- Other: If additional room is needed please use a separate piece of paper
- Ask questions
- Participate in medical appointments
- Request food, drink, object or action

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
  - Report to medical staff pain or other medical needs
  - Request object or actions
  - Other: If additional room is needed please use a separate piece of paper
  - Verbalize physical wants and needs to caregivers and family
  - Communicate with peers, family and others

What are the anticipated needs to warrant an SGD?

- Ability to communicate physical needs and wants
- Socialize with family and caregivers
- Other: If additional room is needed please use a separate piece of paper
- Communicate with medical and educational staff
- Improve expressive language

What features are needed or requested by this client/caregivers and justification for features? If additional room is needed please use a separate piece of paper
### 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.

<table>
<thead>
<tr>
<th>Device TRIaled:</th>
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<tbody>
<tr>
<td>Date Trial Started:</td>
<td>Duration of Trial:</td>
</tr>
<tr>
<td>Direct Select:</td>
<td>Eyes</td>
</tr>
<tr>
<td>Scanning:</td>
<td>One Switch</td>
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Summary: *If additional room is needed please use a separate piece of paper*
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.).

<table>
<thead>
<tr>
<th>Name of Team Member &amp; Role</th>
<th>Phone Number</th>
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Who is responsible for programming, updating, and maintenance of the device?

How has the Pt’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 agree that I am not an employee of, or have a financial relationship, with any assisted technology/speech generating device manufacturer. I agree to the information and recommendations in this report.

_________________________________________ Phone Number ___________________________ Date

Speech-Language Pathologist’s Signature

_________________________________________ Phone Number ___________________________ Date

Physician’s Signature

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