

# Idaho Medicaid SGD Supplemental Form

Please complete entire form and submit with DME Prior Authorization Form

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  |  |                |
|--|--|----------------|
| <b>Summarize Development and Speech/Language Skills: (Attach ST Communication Evaluation. Include inventory of communication skills and sensory function.)</b> |  |                |
| Current Communication Impairment: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe                              |  |                |
| Summarize: <i>If additional room is needed please use a separate piece of paper</i>  |  |                |
| Physical, Cognitive, Hearing, and Vision Abilities and How They Affect the Use of the Requested Device:  |  |                |
| Summarize: <i>If additional room is needed please use a separate piece of paper</i>  |  |                |
| Has Pt Had or Does Pt Have an SGD? <input type="checkbox"/> Yes <input type="checkbox"/> No  | Date of Purchase:  | Length of Use: |
| Current/Previous SGD Make & Model:   | <input type="checkbox"/> Aided <input type="checkbox"/> Unaided <input type="checkbox"/> Low-Tech <input type="checkbox"/> High-Tech |                |
| Any Issues with the Current/Previous SGD: <input type="checkbox"/> Yes <input type="checkbox"/> No   |  |                |
| Explain: <i>If additional room is needed please use a separate piece of paper</i>  |  |                |

Phone: (866) 205-7403

More information is available at [www.dme.idaho.gov](http://www.dme.idaho.gov) and [www.idmedicaid.com](http://www.idmedicaid.com)

REV 04/2019

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:

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

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:

- |  |  |
|--|--|
| <input type="checkbox"/> Express thoughts and ideas in emergency situations                              | <input type="checkbox"/> Verbalize physical wants and needs to caregivers and family |
| <input type="checkbox"/> Report to medical staff pain or other medical needs                             | <input type="checkbox"/> Communicate with peers, family and others                   |
| <input type="checkbox"/> Request object or actions   |  |
| <input type="checkbox"/> Other: <i>If additional room is needed please use a separate piece of paper</i> |  |

What are the anticipated needs to warrant an SGD?

- |  |   |
|--|---|
| <input type="checkbox"/> Ability to communicate physical needs and wants                                 | <input type="checkbox"/> Communicate with medical and educational staff |
| <input type="checkbox"/> Socialize with family and caregivers  | <input type="checkbox"/> Improve expressive language                    |
| <input type="checkbox"/> Other: <i>If additional room is needed please use a separate piece of paper</i> |   |

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.

Device Tried:

Date Trial Started:

Duration of Trial:

Direct Select:

Eyes

Touch

Other:

Scanning:

One Switch

Two Switch

Auditory

Visual

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

Device Tried:

Date Trial Started:

Duration of Trial:

Direct Select:

Eyes

Touch

Other:

Scanning:

One Switch

Two Switch

Auditory

Visual

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

Device Tried:

Date Trial Started:

Duration of Trial:

Direct Select:

Eyes

Touch

Other:

Scanning:

One Switch

Two Switch

Auditory

Visual

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.).

Name of Team Member & Role

Phone Number

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.

\_\_\_\_\_  
Speech-Language Pathologist's Signature

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Date

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