ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

AUGMENTATIVE ALTERNATIVE COMMUNICATION (AAC) REFERRAL PACKET

Instructions for Completion of the Augmentative Alternative Communication Referral Packet
by a certified Speech-Language Pathologist

PRIOR TO COMPLETION OF THE AAC REFERRAL PACKET, THE SLP MUST INFORM THE SUPPORT COORDINATOR THAT AN AAC EVALUATION HAS BEEN DETERMINED MEDICALLY NECESSARY FOR THE MEMBER

AAC Referral Packet Contents:

1) Demographic Information,
2) ISP Information: Please attach a copy of the most current ISP.
3) Insurance Information: Include a legible copy of the private insurance card, including Medicare, both front and back.
4) Evaluator Choice: Please ask the member which provider they would like to have perform the evaluation and training. THIS MUST BE FAMILY CHOICE. In addition, please remind the family that the team completing the evaluation will be responsible for the training as well.
5) Communication Skills Questionnaire (CSQ): Must be completed by a Speech-Language Pathologist holding their Certificate of Clinical Competence (CCC). If you are a CF or SLP-A, the CSQ must be cosigned by your supervising Speech-Language Pathologist. Please add as much description as possible to assist the evaluators in providing a thorough evaluation.

ADDITIONAL INFORMATION FOR SCHOOL SYSTEMS:

1) CSQs completed by school SLPs: Please complete the CSQ in its entirety and submit to DDDAugComms@azdes.gov, the Augmentative Alternative Communication Unit will obtain the remaining information (ISP, insurance, etc.).
2) If the school is completing the AAC evaluation, this packet does not need to be completed. The school system should send the evaluation, including quote page, to DDDAugComms@azdes.gov.

PACKET MUST BE COMPLETED IN ITS ENTIRETY OR THE PROCESS WILL BE DELAYED

Please send completed packet to **DDDAugComms@azdes.gov**.
For mail options, please contact the AAC Department for further instructions via the above email address.

Equal Opportunity Employer / Program • Auxiliary aids and services are available upon request to individuals with disabilities • To request this document in alternative format or for further information about this policy, contact the Division of Developmental Disabilities Customer Service Center at 1-844-770-9500; TTY/TDD Services: 7-1-1 • Disponible en español en línea o en la oficina local

AUGMENTATIVE ALTERNATIVE COMMUNICATION (AAC) REFERRAL PACKET

MUST BE COMPLETED IN ITS ENTIRETY

DATE HCS RECEIVED PACKET

1) MEMBER INFORMATION

Name *(Last, First, M.I.)* ______________________________

AHCCCS or Assists ID Number ______________ Age ______ Date of Birth *(mm/dd/yyyy)* ______________

Address *(No., Street)* ______________________________

City ______________ State ______ ZIP Code ______________ Phone Number ______________

Parent/Guardian's Name ______________________________ Email Address ______________

Address *(No., Street)* ______________________________
(If different from members)

City ______________ State ______ ZIP Code ______________ Phone Number ______________
(If different from members)

Support Coordinator's Name ______________________________

What is the Member's diagnosis? ______________ Who is the Member's PCP? ______________

What language does the family speak? ______________ Does the family need an interpreter? ______________

2) A copy of the most current Individual Support Plan (ISP). Please attach.

3) Does the individual have private health care insurance or Medicare? Yes No

4) A legible photocopy of the private insurance card and/or Medicare Health Plan ID card, front and back. Required. Please attach.

CONTRACTED PROVIDERS *(This must be family choice)*

5) Check (✓) which provider the member/family chooses to administer the Augmentative Communication evaluation.

Member would like the Division to auto-select a vendor
The Division will assign a vendor based on an automatic assignment process

Advanced Therapy Solutions
Services available for Maricopa, Pima, Yavapai, Pinal, Cochise, Gila, and Yuma Counties

MileMarkers Therapy
Services available for LaPaz and Mohave Counties

NAU/Institute for Human Development
Services available for Apache, Cochise, Coconino, Maricopa, Mohave, Navajo, Pima, Pinal, and Yavapai Counties

Southwest Human Development
Services available for Maricopa County

Therapy One
Services available for all counties

COMMUNICATION SKILLS QUESTIONNAIRE (CSQ)
6) Speech – Language Pathologist *(to fill out below)*

Name *(Last, First)* ______________________ Phone Number ______________

Employer Name ______________________ Email Address ______________

How long have you treated the Member? ______________ Frequency/Amount ______________

Is the Member receiving school therapy? ______________ Frequency/Amount ______________

SIGNATURE ______________________ Please Circle: CCC/SLP or CCC/SLP-L DATE SIGNED ______________

CO-SIGNATURE *(If applicable)* ______________________ Please Circle: CF or SLP-A DATE SIGNED ______________

Is your recommendation that the Member would benefit from a communication device? Yes No
Explain in detail why or why not ***(Required)***:

If your recommendation is yes the Member would benefit from a device fill out the questions below.
If your recommendation is no, return this form to the Member's Support Coordinator.

Does this Member already have a device? Yes No

If yes, what kind of device? ______________________

Is this device being used in all settings? Yes No

Is this device being used solely as a communication device? Yes No

Is the Member resistant to using this or any other device? Yes No

Describe the resistance: ______________________

Does this Member require assistance to use the device? Yes No

Describe the assistance needed: ______________________

Is this a request for re-evaluation? Yes No
If yes, describe why:

Diagnoses:

Complete the information below. You may consult with family/therapists. Please add as much descriptive information as possible to assist the evaluators in providing a thorough evaluation.

Based on your interactions with the Member check the applicable boxes below *(Check all that apply)*

Ability to hold head up: Good Fair Poor

Describe: ______

Ability to sit without support: Good Fair Poor

Describe: ______

Muscle tone in arms/hands: Floppy Average Stiff Varies

Describe: ______

Muscle tone in legs/feet: Floppy Average Stiff Varies

Describe: ______

Walking ability: Independently With assistance Does not walk

Describe: ______

Balance: Steady Fair Poor Falls frequently

Describe: ______

Mobility aides: AFO's Cane Crutches Walker Scooter Wheelchair

Other: ______

Describe: ______

If member uses a wheelchair(s):

Manual - Type: ______

Self-propels: Yes No Stroller: Yes No

Power - Type: ______

Drives independently: Yes No Joystick control location: ______

Describe: ______

Describe any problems with the current wheelchair system:

Does the member have upcoming changes in his/her seating system? Yes No

Explain: ______

Does the member use a tray with the wheelchair? Yes No

Describe: ______

Are there any safety or other concerns related to mobility? Yes No

Describe:

Hand preference: Right Left Both Unknown

Describe: ____________________

Ability to use hands: Not able to use hands Right only Left only
With no difficulty With limited movement/coordination

Describe: ____________________

Can pick up and hold: Cup Spoon Cookie Raisin

Describe: ____________________

Can place and let go without dropping: Cup Spoon Cookie Raisin

Describe: ____________________

Can open and close: Buttons Zippers Tie shoelaces

Describe: ____________________

Can point and press buttons of the size found on: Pop machines Elevators Telephones

Describe: ____________________

Member throws things: Not usually Sometimes Often Not at all

Describe: ____________________

Completes writing tasks with *(check all that apply)*: Unable to write Regular pen Adapted pen
Keyboard Other writing aides (dragon): ____________________

Describe: ____________________

Uses other body parts to communicate: Head Eyes Leg Arm Hand
Mouth stick Head stick Other: ____________________

Describe: ____________________

Uses switches to manipulate and control things: Yes No

If yes, indicate types of switches, where they are placed and what activities they are used for:

____

Hearing is functional: Yes No

Describe: ____________________

Does the member use assistive hearing devices? Yes No

If yes, what devices: ____________________

Is the member easily distracted by noisy environments? Yes No

If yes, list the environment: ____________________

Vision is functional: In bright light In low light No functional vision

Describe: ____________________

Does the member wear eye-glasses? Yes No

Comments: ____________________

If the member is considered cortically blind, describe the visual function: ____________________

Can member see pictures that are: Color Black/white Large Small Unknown

Describe: ____________________

Can member follow movement with: Right eye Left eye Both eyes Not at all Unknown

Describe visual tracking ability: ____________________

Describe member's eye contact:

How long can the member maintain their attention? ______________________________

Is the member easily distracted by visual stimulation? Yes No

Describe: ______________________________

Is the member overly sensitive to: Unfamiliar/unexpected touch Touching items Textures Odors Noise Lights Certain foods

Describe the typical reaction: ______________________________

Typical activity level: Low/quiet Average High/very active

Describe: ______________________________

Behaviors observed: Self-stimulation Self-injury Aggression Property destruction

Describe behavior, frequency and when it appears:

Does this member currently have a "Behavior Support Plan"? Yes No

Response to unfamiliar people/places: No significant reaction Withdrawal Run away Interested/engaged Over-excitement

Describe reaction: ______________________________

Motivators, reinforcers, or rewards that work: Attention/social praise Tangibles (e.g. toy, edible) Escape

Other: ______________________________

Describe: ______________________________

Ability to follow simple directions: Good Fair Poor Inconsistent

Describe: ______________________________

Ability to follow multi-step instructions: Good Fair Poor Inconsistent

Describe: ______________________________

Prognosis for functional speech production within the next 12 months: Good Fair Poor

Explain: ______________________________

Current speech production: Vocalizations One word Simple phrases Sentences Conversational speech

Describe in detail:

Percentage of intelligible speech for: __________ % Familiar listeners __________ % Non-familiar listeners

Describe: ______________________________

Oral-motor structures and movements are functional for speech production: Yes No

If no, describe:

Swallowing/feeding concerns: Yes No
If yes, describe:

Drooling: Yes No
If yes, describe:

Respiration/breathing concerns: Yes No
If yes, describe:

Are there any other significant issues in relation to the production of speech? Yes No
If yes, describe:

Member presently communicates using *(check all that apply)*:

Complete words	Incomplete words	Vocalizations	Echolalia
Eye gaze	Gestures	Facial expressions	Sign language
Picture symbol board	Scripted	Spelling/word board	Speech
Communication device	Other: ______		

Initiates communication: Not at all Inconsistent Consistent
Describe:

Responds to communication: Not at all Inconsistent Consistent
Describe:

Gains attention: Not at all Inconsistent Consistent
Describe:

Expresses wants and needs: Not at all Inconsistent Consistent
Describe:

Makes choices: Not at all Inconsistent Consistent
Describe:

Asks questions: Not at all Inconsistent Consistent
Describe:

Describes a sequence of events: Not at all Inconsistent Consistent
Describe:

Expresses feelings and emotions: Not at all Inconsistent Consistent
Describe:

Uses repair strategies: Not at all Inconsistent Consistent
Describe:

Uses turn taking: Not at all Inconsistent Consistent
Describe:

Follows directions: Not at all Inconsistent Consistent
Describe:

Understands social routines and humor: Not at all Inconsistent Consistent
Describe:

Recognizes/discriminates symbols/pictures: Not at all Inconsistent Consistent
Describe:

Reads: Not at all Inconsistent Consistent
Describe:

Spells: Not at all Inconsistent Consistent
Describe:

Member demonstrates comprehension of:

Own name: Yes No
Explain:

“Yes”: Yes No
Explain:

"No": Yes No
Explain:

Object identification: Yes No *List:* ____________________
Explain:

Object function: Yes No *List:* ____________________
Explain:

1-step requests/directions: Yes No
Explain:

2-step requests/directions: Yes No
Explain:

Multi-step requests/directions: Yes No
Explain:

Body parts: Yes No *List:* ____________________
Explain:

Prepositions: Yes No *List:* ____________________
Explain:

Quantity: Yes No *List:* ____________________
Explain:

Categories: Yes No *List:* ____________________
Explain:

Sequencing: Yes No *List:* ____________________
Explain: