To view printable form click here: Augmentative Communication Device Selection Report

471-000-207 Example of Form MS-78, "Augmentative Communication Device Selection Report"

Augmentative Communication Device Selection Report

1. CLIENT INFORMATION

Name _____
Address _____
City _____ State _____ Zip _____
Birthdate _____ Medicaid # _____
Medical Diagnosis _____
Speech-Language Diagnosis _____

2. EVALUATOR INFORMATION

Speech-Language Pathologist _____
License # _____
Facility _____
Address _____
City _____ State _____ Zip _____
Telephone (_____) _____
Physician _____
Specialty _____
License # _____

3. DEVICE INFORMATION

Attach itemized list of devices and accessories recommended, the manufacturer of each item and the cost for each item.

Distributor/Dealer _____

4. PHYSICAL STATUS PER DOCUMENTATION

	Adequate	Inadequate	Non-essential
a. Hearing	☐	☐	☐
b. Vision	☐	☐	☐
c. Head Control	☐	☐	☐
d. Trunk Stability	☐	☐	☐
e. Arm Movement	☐	☐	☐
f. Seating/Positioning For Use of Device	☐	☐	☐

	Yes	No	To what extent
g. Able to Ambulate?	☐	☐	_____
h. Requires Wheelchair?	☐	☐	_____

i. Summary _____

5. COMMUNICATION ABILITIES

	Present	Absent
a. Attempts to communicate with consistent response mode	☐	☐
b. Ability to make choices	☐	☐
c. Understands that communication will cause an action to occur	☐	☐
d. Understands that symbols (e.g. words, pictures, Bliss, sign) stand for verbal communication	☐	☐

	Guarded	Poor	Absent
e. Prognosis to develop intelligible speech	☐	☐	☐

f. Estimate client's current vocabulary size _____

6. SELECTION OF DEVICE

a. Client's current means of communication _____
b. Results of communication needs assessment _____
c. Other devices considered and rationale for elimination _____
d. Rationale for selection of specific device:
1. Control of the device _____
2. Symbols (type and size) _____
3. Message storage and retrieval capability _____
4. Communication output of the device _____
5. Mounting of the device _____
e. Indicators for success:
1. Indications that client able to use device _____
2. Has client used the device? ☐ Yes ☐ No
How long? _____ Under what conditions _____
3. Describe your observations of client using device _____

f.

	Name of Standardized Test	Scores (If applicable)
Spelling	_____	_____
Reading	_____	_____
Cognition	_____	_____

g. Results of informal assessment _____

7. PLAN OF IMPLEMENTATION FOR USE OF DEVICE

a. Who will teach client to use device _____
b. How will parent/caregiver implement use of device _____
c. Environments and goals for use _____

8.

Physician _____ (Signature) _____ (Date) Speech/Language Pathologist _____ (Signature) _____ (Date)

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MS-78 Rev. 1/93 (27080)
(Previous version 4/90 should not be used)

COMPLETION INSTRUCTIONS

USE: Form MS-78 is required for review with requests for prior authorization of augmentative communication devices as outlined in 471 NAC 7-000.

COMPLETION: Form MS-78 must be completed in entirety by the licensed speech-language pathologist who has evaluated the client's augmentative communication needs as follows -

Note: Attach separate pages to continue responses, if necessary. Other documentation which you feel would be relevant to this request may also be attached.

1. CLIENT INFORMATION

- Client's full NAME
- Client's complete home ADDRESS, CITY, STATE and ZIP CODE
- Client's BIRTH DATE
- Client's 11-digit MEDICAID NUMBER
- Client's MEDICAL DIAGNOSIS
- Client's SPEECH-LANGUAGE DIAGNOSIS

2. EVALUATOR INFORMATION

- Full name of SPEECH-LANGUAGE PATHOLOGIST who evaluated the client.
- Speech-Language pathologist's LICENSE NUMBER
- Name of FACILITY where the client is receiving evaluation/treatment
- Facility ADDRESS, CITY, STATE, ZIP CODE, and TELEPHONE NUMBER
- Full name of client's attending PHYSICIAN
- Physician's SPECIALITY
- Physician's LICENSE NUMBER

3. DEVICE INFORMATION

- Attach itemized list of DEVICES and ACCESSORIES recommended, the MANUFACTURER of each item and the COST for each item.
- Name of the Medicaid-enrolled DISTRIBUTOR or DEALER who is the local supplier for the device.

4. PHYSICAL STATUS

a-h. Check the box which characterizes the client's current physical condition according to the medical/clinical documentation or personal observation.

Note: "Adequate" and "inadequate" ratings relate to physical parameters only as they apply to the use of the specific communication device recommended. "Nonessential" rating indicates status is not related to use of the device for this client.

i. Provide a narrative summary of physical status.

5. COMMUNICATION ABILITIES

a-e. Check the appropriate box which best describes the client's current cognitive status.

f. Estimate the client's current vocabulary size.

6. SELECTION OF DEVICE

a. Describe how the client CURRENTLY COMMUNICATES and why it is not adequate to meet his/her communication needs.

b. Describe results of COMMUNICATIONS NEEDS ASSESSMENT.

c. List OTHER DEVICES CONSIDERED for the client and explain why they would not be appropriate.

d. Outline the RATIONALE FOR SELECTION of the recommended device by answering the following -

1. How does the client control the device?
2. What are the type and size of symbols used with the device?
3. What are the device's message storage and retrieval capabilities?
4. How does the device communicate to the listener?
5. What type of mounting will the device require?

e. Outline the INDICATORS FOR SUCCESS with the recommended device by answering the following -

1. What are the indications that the client can use the device?
2. Has the client had the opportunity to use the device? If so, for how long and under what conditions?
3. How have you observed the client using the device (e.g., calls for attention, initiates conversation, answers questions, asks for help, makes requests, etc.)?

f. If applicable, provide the name of the TESTING instrument and the scores obtained.

g. Provide a summary of the client's capabilities and needs based on INFORMAL ASSESSMENT in the following areas: motor control, sensory, vision, hearing, language, and cognition.

7. PLAN OF IMPLEMENTATION FOR USE OF DEVICE

a. Who will be responsible for TEACHING the client to communicate with the device?

b. How will the client's PARENT/CAREGIVERS be taught to implement use of the device?

c. In which ENVIRONMENTS will the client use the device (e.g., home, school, community, work, etc.) and what are the COMMUNICATION GOALS for those environments?

8. SIGNATURES

Form MS-78 must be signed and dated by the speech-language pathologist who evaluated the client and by the client's attending physician.

DISTRIBUTION: Submit the original copy of Form MS-78 to the Nebraska Department of Social Services, Medical Services Division, P.O. Box 95026, Lincoln, NE 68509-5026. Keep a duplicate copy for your records.