Iowa Department of Human Services

AUGMENTATIVE COMMUNICATION SYSTEM SELECTION

Recipient Name	Medicaid Number	Date of Birth	
Address	City	State	Zip

Section A To be completed by physician. Use additional sheets as needed.

Medical diagnosis and history:

Medical prognosis:

Physician Signature	Name
Address	Phone

Section B To be completed by speech or language pathologist. Use additional sheets as needed.

Please describe current functional abilities in terms of:

Communications Skills:

Motor Status:

Sensory Status:

Cognitive Status:

Social/emotional status:

Language Status:

Information is also needed on the following:
Educational ability and needs:

Vocational potential:

Anticipated duration of need:

Prognosis regarding oral communication skills:

Prognosis with a particular device: (Has there been a trial period with this or a similar device?)

Recommendation: (Why this particular device? What other kinds of equipment have been used?)

Speech or Language Pathologist Signature	Name
Address	Phone

Section C To be completed by consultant or fiscal agent

Communication System ❑ Approved ❑ Denied

Type _____
Reason _____
Signature _____