

**FORWARDHEALTH
PRIOR AUTHORIZATION / SPEECH-GENERATING DEVICE
PURCHASE RECOMMENDATION ATTACHMENT**

INSTRUCTIONS: Type or print clearly. Before completing this form, read the Prior Authorization/Speech-Generating Device Purchase Recommendation Attachment Instructions, F-02493A. Providers may refer to the Forms page of the ForwardHealth Portal at www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/ForwardHealthCommunications.aspx?panel=Forms for the completion instructions.

The speech-language pathologist is required to complete the Prior Authorization/Speech-Generating Device Skills and Needs Profile Attachment form, F-02494, and the Prior Authorization/Speech-Generating Device Purchase Recommendation Attachment form, or to submit a speech and language pathology (SLP) report documenting the same content as the two attachments. The speech-language pathologist is required to submit the completed forms or documentation to the speech-generating device (SGD) vendor with any additional required documentation attachments. The SGD vendor may submit the forms and any required documentation by fax to ForwardHealth at 608-221-8616 or by mail to ForwardHealth, Prior Authorization, Suite 88, 313 Blettner Boulevard, Madison, WI 53784.

SECTION I – MEMBER INFORMATION

1. Name – Member (Last, First, Middle Initial)

2. Member ID Number

3. Date of Birth – Member (mm/dd/ccyy)

SECTION II – SERVICE INFORMATION

4. Medical Diagnosis

5. Treatment Diagnosis

6. Did the member receive SGD treatment following completion of the skills and needs profile?

Yes No

If yes, list the start date, end date, and frequency of treatment.

Treatment Start Date _____

Treatment End Date _____

Frequency of Sessions _____

7. Has the member participated in an SGD trial?

Yes No

If yes, list the start and end date of the trial period.

Trial Start Date _____

Trial End Date _____

SECTION III – DOCUMENTATION OF SGDS CONSIDERED BUT RULED OUT

8. Describe any SGD options considered but ruled out during the skills and needs profile assessment, treatment sessions, or the trial period. If relevant, highlight why other SGD options were eliminated from further consideration for the member, including less costly alternatives.

SECTION IV – RECOMMENDED SGD AND DESCRIPTION OF FEATURE MATCH

9. Identify SGD hardware (include name and manufacturer), and describe feature match (for example, portability, durability, battery life, size of display).

10. Identify SGD software, and describe feature match (for example, symbols, navigation, and display features such as static or dynamic display, visual scene, grid, list, symbol size, spacing, and number on display).

11. Language System / Organization / Page Set (Select all that apply.)

- Phrase-Based Word-Based Text-Based
- Word Prediction Message Storage Features Bilingual Language Features
- Vocabulary Appropriate to Age and/or Cognitive Level
- Encoding Including Semantic Compaction
- Related Page Sets to Allow for Transition to More Complex Options as Language Advances

Describe feature match to selected options.

12. Access Method, Settings, and Accessories (Select all that apply.)

- Adapted Touch Screen Settings and/or Key Guards
- Direct Selection Using Finger or Hand Without Adaptations
Select One: Right Hand Left Hand Both
- Direct Selection Using Adaptations Such as Head Pointer or Head Mouse
- Eye Gaze
- Joystick or Mouse
- Scanning

Describe switches, switch placement, and type of scanning.

- Other (If Other, describe.)

Describe feature match with recommended access methods, settings, and accessories. Attach occupational therapy (OT) or physical therapy (PT) reports if relevant.

13. Identify adaptations, accessories, or mounts if relevant. Describe feature match to identified options. Attach OT or PT reports if relevant.

**SECTION V – SUMMARY OF PROGRESS DOCUMENTED AS A RESULT OF TREATMENT OR TRIAL PERIOD
(Complete this section if “Yes” is checked for either Element 6 or Element 7.)**

14. Provide details necessary to document how the member’s ability to communicate improved with the use of the SGD. Include documentation of the SGD trial period here. Documentation should target:

- **How the member communicated at the start of treatment with the SGD.** Examples of documentation may include, but are not limited to: baselines of established goals, frequency and types of cues, activity selection, or activity structure for targeted SGD use.
 - **How the member currently communicates with the device.** Examples of documentation may include, but are not limited to: measureable change from baseline performance, changes in frequency and types of cues, changes in activity selection or activity structure, examples of generated messages, interactions with caregivers/family members or school staff and care providers, or other situations relevant to the treatment implemented.
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SECTION VI – SGD PURCHASE RECOMMENDATION WITHOUT THE NEED FOR SGD TREATMENT OR A TRIAL PERIOD (Complete this section if “No” was checked for both Elements 6 and 7.)

Note: Complete this section once the SGD and accessories (if relevant) have been matched to the skills and needs of the member and the member has demonstrated relevant skills using the SGD.

15. Provide documentation of relevant skills for the member to use the SGD. Documentation should target:

- **Relevant skills**, including language skills (for example, vocabulary, syntax), social skills (for example, communicative functions), and operational skills (on/off, navigation).
- **Relevant context requirements** (for example, frequency or types of cues), including examples of messages produced as part of completion of skills and needs profile. If relevant, include rationale for not requiring SGD treatment or a trial period to confirm recommendation (for example, degenerative diagnosis, history of using an SGD).

SECTION VII – SUPPORT FOR RECOMMENDED SGD AND DOCUMENTATION OF TREATMENT NEEDS

16. Document evidence that the family and/or team members are able to provide essential supports relevant to the SGD matched to the member's skills and needs. Provide examples of use across environments with cue levels if applicable. (Communication logs kept during the trial period may be attached).

Home

School

Community

17. Recommendations for SLP Treatment Following Placement of Recommended SGD (Select all that apply.)

- The member does not require SGD treatment following the placement of the recommended SGD. Provide rationale for why the member does not require treatment.

- The member requires SGD treatment following the placement of the SGD to address communication needs, support participation in routines, or advance expressive language skills. Check all relevant items below and provide requested information.
 - The member will receive needed treatment as part of school-based services. The current Individual Education Plan (IEP) is attached.
 - The member will receive needed treatment through a private or medical-based SLP and an updated treatment plan is recorded below. (An updated treatment plan may be attached.) The treatment plan should include long- and short-term goals, and anticipated frequency and duration of SLP treatment following the receipt of the SGD. The speech-language pathologist should include their plan for coordination of care with other providers.

- Other:

Treatment Plan:

Note: If the member receives Birth to 3 services or school-based services, attach the IEP or Individual Family Services Plan (IFSP) to the purchase recommendation documentation.

SECTION VIII – AUTHORIZED SIGNATURE

18. SIGNATURE AND CREDENTIALS – Speech-Language Pathologist	19. Date Signed
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