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:

Communication Skills:

Motor Status:

Sensory Status:

Cognitive Status:

Social/Emotional Status:

Language Status:

Educational ability and needs:

Vocational potential:

Anticipated duration of need:

Prognosis regarding oral communication skills:

Prognosis with a particular device:

Equipment recommendations:

SLP Signature	Name:
Address:	Phone:

Section C: To be completed by consultant or fiscal agent

Communication System: □ Approved Type _____

□ Denied Reason _____

Signature _____