## QUESTIONNAIRE #13

### AUGMENTATIVE COMMUNICATION DEVICE

**Member Name**

**Health First Colorado ID #**

**Length of Need**

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**Note:** A questionnaire is not an assessment tool. The information requested below is required to determine medical necessity. Complete this form and attach to the completed Prior Authorization Request (PAR).

1. **What is the complete diagnosis with complicating factors?**

2. **Is the member’s speech understood less than 25% of the time by an unfamiliar listener?**
   - □ Yes  □ No

3. **Is lack of speech:**
   - a. **Is improvement expected without the aid of an ACD?**
     - □ Yes  □ No
   - b. **If yes, how soon?**

4. **Does member have ability to effectively use a communication device (including tablet)?**
   - a. **Explain.**
   - □ With caregiver help  □ Without caregiver help

5. **Has the member received a course of speech therapy?**
   - a. **If yes, notate length of time and frequency.**
   - □ Yes  □ No
   - **Length of time**
   - **Frequency**

6. **Is this request for the initial two (2) month trial period?**
   - □ Yes  □ No

7. **Is this request post two (2) month trial period?**
   - a. **If yes, what devices were trialed?**
   - □ Yes  □ No

8. **Supply any additional information that will assist us in determining medical necessity for this request:**

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**Note:** A separate PAR must be submitted for each trial period and purchase.

Print Medical Professional Name

Medical Professional Signature

Date

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