

Beneficiary Name: \_\_\_\_\_ Medicaid#:

Speech Language Pathology Evaluation Date:   /   / 20   Re-evaluation Date:   /   / 20

Diagnoses/Conditions being Addressed (Describe specific problems requiring therapy.)		
	Description (e.g., Medical - CVA, Therapy - paralysis of lower limb)	ICD-9 Codes:
Medical Diagnoses:		<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>
		<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>
Therapy Diagnoses:		<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>
		<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>

**History Related to Diagnosis and Therapy:**

**I. Date of Onset:**   /   /

**II. Recent Hospitalizations/Dates:**

**III. Pertinent Medical History:** [mechanism of injury, diagnostic imaging/testing, medications, co morbidities (complicating or precautionary information)]

**IV. Prior Therapy History for Same Diagnosis/Condition and Response to Therapy:**

**V. Social History:** (Identify primary caregiver, effects of the disability on the beneficiary and the family, architectural/safety considerations present in the living environment and caregiver's ability/inability to assist with therapy)

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**VI. Level of Function:** *(Initial Evaluation – record functional level prior to current condition. For Reevaluation, record the patient’s original functional level prior to institution of therapy and current functional level.)*

**VII. Clinical Status/Impairments:** *[assistive/adaptive devices (currently used or required), oral motor function, phonation, speech production, articulation, stimulability, voice fluency, receptive and expressive language articulation, feeding/swallowing ability, muscle performance, neuromotor development, pain, reflex integrity, hearing ability, vision and cognitive/orientation skills, assessment of the beneficiary’s potential for rehabilitation, sensory integrity, age appropriate information on all children (e.g. chronological age/corrected age), motivation for treatment, special/standardized tests including the name, scores/results, and date administered, other significant physical or mental disabilities/deficiencies]*

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**VIII. Impression/Interpretation of Findings:**

**IX. Discharge Plan:** *(including requirements to return to home, school and/or job)*

**Attestation Statement:** *A therapy provider who knowingly or willfully makes, or causes to be made, any false statement of representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under Federal and State criminal laws and/or may be subject to civil monetary penalties and/or fines. I certify that I am the therapy provider who performed the therapy evaluation / reevaluation on the Medicaid beneficiary listed on this form. I certify that the information provided on the Evaluation/Reevaluation Form is true, accurate, and complete to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil monetary penalties, fines, or criminal prosecution, or disqualify me as a provider of Medicaid services.*

\_\_\_\_\_  
**Signature and Title of Speech Language Pathologist**

\_\_\_\_\_  
**Date**

**Beneficiary Name:** \_\_\_\_\_ **Medicaid#:**

**Important Notice: When entering information on the Addendum Page, please reference the appropriate section.**  
(For Example: II. Recent Hospitalizations/Dates: ORIF right arm on 06/01/09)