

Beneficiary Name: _____ **Medicaid#:**

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

Diagnoses/Conditions being Addressed <i>(Describe specific problems requiring therapy.)</i>		
	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

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Important Notice: When entering information on the Addendum Page, please reference the appropriate section.
(For Example: II. Recent Hospitalizations/Dates: ORIF right arm on 07/01/06)