EXHIBIT B
Augmentative Communication Device Training Report

This form to be completed for each Training Service

DDD MEMBER NAME (Last, first, MI)	**DATE OF BIRTH**	**AHCCCS #**
DDD MEMBER ADDRESS (No. Street, City, State, Zip)		
RESPONSIBLE PERSON'S NAME	**PHONE NUMBER** (Include area code)	
CONTRACTOR NAME	**CONTRACTOR PHONE** (Include area code)	**CONTRACTOR FAX** (Include area code)
NAME OF PRIMARY TRAINER	**QUALIFICATION** ☐ Speech Language Pathologist ☐ Assistive Technology Specialist	
NAME OF ADDITIONAL TRAINER	**QUALIFICATION** ☐ Speech Language Pathologist ☐ Assistive Technology Specialist	
PHYSICIAN'S NAME		
CPT CODE (Optional)	**DIAGNOSIS**	**SUPPORT COORDINATOR'S NAME**
BRAND NAME OF DEVICE	**MODEL NUMBER AND/OR DESCRIPTION**	**ACCESS TYPE**
ACCESSORIES (if applicable)	**MOUNT** (if applicable)	
DATE DEVICE RECEIVED	**DATE DEVICE INSTALLED** (if applicable)	**NAME OF INSTALLER** (if applicable)
NO SHOW or CANCELLATION DATES AND REASON FOR MISSED APPOINTMENTS		

Training Date:	Training Provided To: (Parent, SLP, etc.)	Content of Training: (Programming, Access, etc.)

Summary of Training Progress:		
Is the parent/caregiver demonstrating competency with the device?	Yes ☐	No ☐
If no, explain why:		
Does the parent/caregiver demonstrate willingness to use the device in all environments?	Yes ☐	No ☐
If no, explain why:		
If additional hours are being recommended for authorization, explain why, and the new number of recommended hours. Name of Individual Making Recommendation:		
Other:		
Name/Credentials of Individual Completing this Report:	Date:	

Routing to:
Support Coordinator and DDDAugComms@azdes.gov