Upfront

Speech generating devices (SGDs) are being funded by more funding programs than ever before. The foundation for AAC device funding in many countries has never been stronger. In the United States, for example, there are no political or fiscal storms raging or forming on the horizon that threaten this period of calm. Lewis Golinker, a U.S. attorney who has been advocating to expand and protect AAC device funding opportunities since 1982, says:

> SGD funding issues in the U.S. can be compared to a high cholesterol count. Both require constant attention, but there are things you can do to keep them under control, and despite these issues, you can live a normal, active life.[1]

SGD funding in any country does not just happen. It typically evolves over decades as a result of vigorous and continuing advocacy. The AAC community opens up funding streams by first identifying why government and private funding sources should cover SGDs and related services and then advocating for coverage while monitoring each funding source. It is also essential for researchers, clinicians and advocates to systematically and rigorously collect facts and arguments that define the benefits of SGDs for people with complex communication needs (CCN) and thus, address funding challenges.

Clinical News summarizes information about ten U.S. funding

sources. Collectively, these programs represent the broad scope of available AAC funding in a country with 300 million people. Each funding program targets a specific population or purpose and has its own financing scheme. These programs don't necessarily agree on what to call AAC devices (*e.g.*, powered communication systems, speech generating devices, augmentative communication devices) and they pay for them under different funding categories (*e.g.*, durable medical equipment, prosthetic devices, assistive technology devices,

Clinical News

Ten U.S. Funding Programs **with Lewis Golinker**

The information provided in this article was taken in part from the recently launched website www.aacfundinghelp.org.[2] See **On the Web**.

Third-party funding programs are responsible for almost all purchases of speech generating devices (SGDs) in the United States.* This article summarizes the ten funding programs in the U.S. that currently fund SGDs. According to Lewis Golinker:

> Each funding and benefits program in the United States that reasonably could be a source of funding for SGDs now *is* a funding source. In other words, we no longer have any policy-based coverage or funding barriers to SGDs. Even so, these ten programs, either singly or

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* Only the least expensive digitized speech output SGDs are purchased directly.

collectively, do not ensure that every American who needs an SGD will have a source of financial assistance to acquire one. Some people still fall through the safety net and can not access third-party funding. While their numbers are small, this fact is unfortunate and requires our ongoing vigilance.[3]

Each of the ten programs targets a specific population or a specific need, and some individuals are covered by more than one program. Also, while SGD coverage is common to all ten programs, the programs are quite distinct. For example, programs vary in purpose (*e.g.*, health, education, vocational rehabilitation and telephone access) and in administration (*i.e.*, every level of government is represented—federal, state, local as well as private entities.) Also, program terminology is often unique (*i.e.*, SGDs are known as items of durable medical equip-

Clinical News, Continued from page 1

ment or prosthetic devices to health programs, assistive technology to educational and vocational rehabilitation programs and specialized telecommunications equipment to telephone access programs. [See Table I.] A brief description of each program follows.

Medicare

Medicare was created in 1965 to provide financial assistance so that older Americans (age 65 and older) could obtain necessary health care. Medicare has since been expanded to include two additional groups:

1. Individuals younger than age 65 who paid Medicare taxes while working and who become disabled. These disabled former workers are eligible for Social Security Disability Insurance (SSDI) benefits, and after a 24-month wait period, they are eligible for Medicare. [Note: See Figure 1 for ALS exception.]

2. Children with disabilities who have a Medicare-eligible parent (either by disability or age) or whose parent has died.

Table I. Terminology differences across funding programs	
Durable medical equipment (DME)	SGDs are covered as items of durable medical equipment by Medicare, a majority of Medicaid programs and insurance/health benefits plans.
Prosthetic devices	SGDs are covered as prosthetic devices by Tricare, the Department of Veterans Affairs and some Medicaid programs, as well as some insurers and health benefits plans.
Assistive technology devices	SGDs are covered as assistive technology devices by special education, early intervention and vocational rehabilitation programs.
Telecommunication devices/equipment	SGDs are covered as telecommunications devices or specialized telecommunications equipment by Telecommunications Equipment Distribution Programs (TEDP).
Powered communication systems	In 1983, the U. S. Food & Drug Administration (FDA) recognized SGDs as medical devices "used for medical purposes." The FDA continues to call SGDs "powered communication systems."

Medicare is administered directly by the federal government, but it contracts with numerous insurance companies to make day-to-day administrative decisions on funding requests. Medicare offers a wide

specialized telephone equipment.) Not surprisingly, there are coverage gaps and overlaps among programs, and in some cases, they simply must work together. Confusing? To be sure.

On The Web announces a new website launched in November 2006 [*www.aacfundinghelp.com*]. This comprehensive site focuses initially on U.S. funding, but in 2007 will add information about Canada and the United Kingdom. *Governmental* addresses funding practices in several other countries. While the information is incomplete at best, the article underscores the challenges we face in SGD funding internationally. In addition, it can remind us that we have the potential to learn from and to support each other's efforts in removing SGD funding barriers for

all citizens on the planet.

For those who have registered for 2006 CEUs, your quiz is enclosed. The quiz and other CEU materials are due on January 15, 2007. Thanks to all who helped with this issue (see page 8). Thanks especially to Lewis Golinker, a guru of AAC funding, who supplied much of the content.

May you have a happy holiday season with family and friends.
Sarah W. Blackstone, Ph.D., CCC-SP

Figure 1. Special access to SGDs for people with ALS

People with ALS benefit from rules that make them eligible for Medicare faster than people with other conditions. Those who meet the work requirements for Social Security Disability Insurance (SSDI) benefits who are younger than 65 become immediately eligible for SSDI upon receipt of an ALS diagnosis and cessation of work and then become immediately eligible for Medicare.

Muscular Dystrophy Association (MDA). The MDA offers up to $2000 in financial assistance for persons with ALS to purchase an SGD, meet the Medicare co-payment obligations, or pay for accessories that may not be covered by Medicare, *etc*. Some MDA offices allow individuals to use funds for training or other services. [Note: MDA also provides up to $2000 for mobility device purchases.]

array of benefits under different categories:

Medicare Part A. Access to hospital care and short-term rehabilitative care in a nursing facility.

Medicare Part B (also known as supplemental insurance). Payments for physician services, outpatient therapies (*e.g.*, speech-language pathology (SLP), OT and PT services), durable medical equipment (DME), and prosthetic devices. [Note: SGDs are covered as items of DME under Medicare Part B.]

Medicare Part C. A managed care option.

Medicare Part D. Prescription drugs.

The history. In the late 1980s, Medicare issued a *national coverage guidance*, which called AAC devices *convenience items* rather than items of DME and declared them 'not covered.'** Medicare re-examined this guidance in the late 1990s with the assistance of a work-group of AAC professionals, and after an 18-month inquiry, agreed to rewrite its AAC device coverage policy. In January 2001, Medicare put into effect two new guidelines that specifically supported Medicare coverage of SGDs, com-

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** Medicare never provided a basis for this conclusion.

pletely reversing its previous *convenience item* conclusion.[4]

Medicare policy clearly defines SGDs (see Table II) and it establishes codes based on key device features that are factors in its reimbursement policy; six codes are for SGDs; three are for SGD software, mounts and accessories.[5] Four DMERCs (Durable Medical Equipment Regional Carriers) are responsible for decisions about Medicare funding requests for SGDs.

Current information. The Medicare section of the website *www.aacfundinghelp.com* offers AAC stakeholders *all-you-need-to-know* about Medicare, eligibility for SGDs, current Medicare SGD coverage guidance, Medicare SGD and accessory codes and fee schedules, as well as the basics about Medicare payments. [There is a 20% co-payment requirement.] The site also describes Medicare coverage of eye-gaze technologies and has specific information for people with ALS and their family members (see Figure 1). It includes information about rentals, repairs, replacement devices and Medicare's scope of coverage of computer- and PDA-based devices. Finally, the website delineates the components of an SLP assessment and report, physician prescription and facts about Medicare reimbursement rates for SLP assessment and treatment services.[5]

The impact. Medicare is now the single largest purchaser of SGDs. Also, as the largest insurer in the U.S., Medicare's SGD coverage has affected the ways other funding programs consider SGDs. Insurers, in particular, are now far more accepting of SGD coverage and many have adopted the Medicare SGD coverage guidance and terminology for their own use.

Table II. Medicare Definition of a Speech Generating Device	
WHAT AN SGD IS	WHAT AN SGD IS NOT
1. A dedicated speech device used solely by the individual who has severe speech impairment.	1. Also can run a word processing package, an accounting program, *etc*.
2. A digitized speech output device using pre-recorded messages, less than or equal to 8 minutes recording time.	2. Perform other non-medical functions.
3. A digitized speech output device using pre-recorded messages, greater than 8 minutes recording time.	3. Devices that are useful to someone without severe speech impairment.
4. A synthesized speech output device that requires message formulation by spelling and device access by physical contact with the device, *i.e.,* direct selection techniques.	4. Laptop computers, desktop computers or PDAs that are not primarily medical in nature and do not meet the definition of prosthetic, prosthetic device, prosthetic supply or durable medical equipment.
5. A synthesized speech output device that permits multiple methods of message formulation and multiple methods of device access.	5. Communication aids that do not generate speech.
6. Software that allows a laptop computer, desktop computer or personal digital assistant (PDA) to function as a speech generating device.	6. Picture books; flashcards; Braille typewriters; TTY devices; devices that rely on writing rather than synthesized speech.
7. Computer-based and PDA-based SGD that has been modified to run ONLY SGD software.	7. Devices that allow the user to communicate with a computer rather than a person.

Note: For those interested in how the current Medicare guidance was developed, there is a detailed review of Medicare AAC device coverage policy reform efforts at www.aacfundinghelp.com.

Medicaid

Medicaid and Medicare were created together in 1965 with each targeting a distinct population. Medicaid was created to provide financial assistance to enable individuals with limited incomes and resources, as well as families with dependent children, people who receive or are eligible for Supplemental Security Income (SSI), pregnant women who meet income requirements and those who receive adoption or foster care assistance, to obtain necessary health care.

The Medicaid program is a voluntary program, not a federal mandate. Thus, states must choose to participate. All do. Participating states must agree to follow the requirements of the federal Medicaid Act as well as specific federal regulations and guidelines. In exchange, the federal government promises to pay between 50 and 80 percent of the states' Medicaid program costs.

Federal Medicaid requires coverage of specific groups of individuals and specific services. However, each state has the option to extend Medicaid coverage to additional groups of individuals and to offer as many as three dozen additional services. Regardless of the options a state may choose, the federal payment offer remains the same.

The history. The origins of Medicaid coverage of SGDs date back to the late 1970s when SGDs were first made commercially available. Coverage has gradually widened state-by-state. Often coverage was expanded informally and voluntarily, but in approximately one-third of the states, lawsuits were required to remove coverage barriers. By 2000, all Medicaid programs covered and provided SGDs to both children and adults.

Current information. SGD coverage by Medicaid is almost exclusively done within the DME benefit category, although a few states classify SGDs as prosthetic devices or as *necessary equipment*

within a SLP benefit. Medicaid programs cover a full range of SGDs, including those that are computer- or PDA-based. Administratively, Medicaid is noteworthy in three respects.

1. Almost every Medicaid program has written specific SGD coverage or clinical criteria that outline the scope of the SLP assessment and report that must accompany each funding request.[6]

2. Medicaid programs in every state (except New York) require *prior authorization*, a procedure in which a completed funding request (SLP evaluation and physician's prescription) is submitted through the device manufacturer or supplier and then reviewed by Medicaid staff before the item or service can be provided.

3. Because Medicaid was designed to serve individuals with limited incomes, suppliers must accept Medicaid as payment in full. Unlike insurance in which co-payments are common, or Medicare, where a 20% co-payment is the rule, Medicaid recipients may make no contributions to the costs of the equipment or services they receive.

Insurance Companies and Health Benefit Plans

Health insurance is typically provided as a fringe benefit to employment and is delivered in two distinct ways:

1. The employer purchases an insurance policy for the benefit of its employees (or an individual purchases an insurance policy directly).

2. The employer creates a "health benefits plan," which it funds directly from company assets.

Because each employer can design its own policy or plan, the potential for variation is unlimited. However, in practice, just about all policies and plans cover DME and most use Medicare's DME definition.

The history. After Medicare's SGD coverage decision in 2001, the numbers of insurers that cover and provide SGDs increased significantly. The *AACFundingHelp*

website includes an Insurers' Approvals database that lists more than 1,000 insurers and health plans that have approved SGDs.[7]

Current Information. SGDs are available to all persons covered by a policy or plan. Typically, SGDs are classified as items of DME or as prosthetic devices. Procedurally, as with Medicare and Medicaid, an insurance or health plan funding request must typically be supported by an SLP assessment and a doctor's prescription. Some insurers and plans follow Medicaid's prior authorization procedure, while others follow Medicare's requirement that the SGDs be purchased first, and then the claims submitted. SLPs should always check for guidance when preparing a funding request.

Dealing with denials. When an insurer or health benefit plan denies an SGD funding request, it is important to check the Insurer Approvals Database to ascertain whether an insurer previously has approved a claim. If the answer is "yes," and the insurer says their current policy or plan requires a "no", then the SLP should request (in writing) that the insurer (1) identify all differences between the prior policy or plan and the current one, and (2) explain the significance of those differences. Regardless of the type of denial, there is a good chance it can be overturned. Examples of denial reasons follow:

1. SGDs do not fit within our scope of policy or plan. Insurers may give many reasons why SGDs do not "fit" within a plan. There is strong objective evidence to contradict each of these.

• SGDs are not DME.

• SGDs are not medical in nature.

• SGDs are not covered.

• SGDs are useful to people without severe communication impairments (*e.g.*, useful in the absence of illness or injury.)

• SGDs are not treatment.

• SGDs are not medically necessary.

• SGDs are not treatment for an underlying condition.

• SGDs are a convenience item.

• SGDs have no medical purpose.

• SGDs are prescribed soley for educational or vocational purposes.

2. SGDs are excluded in our policy/plan. Policies or plans sometimes clearly state that SGDs are not covered. Even so, exclusions can be challenged. For example, while insurance policies and plans have wide latitude within which to write their scope of coverage (and their exclusions), they do not have a completely free hand. State law for insurance policies and the Americans with Disabilities Act prohibit disability-based discrimination in the scope of benefits provided. Thus, a plan or policy can be challenged if it offers a DME benefit for wheelchairs to people with mobility impairments and excludes SGDs to people with severe speech impairments, because that is disability-based discrimination and is not permitted.

Also, there is no cost justification to support the exclusion of SGDs in insurance policies and plans. Earlier this year, a report was prepared by the nation's leading health actuary firm, Milliman, Inc., to examine the costs of including SGD coverage in a typical insurance policy or plan. Milliman's conclusion was that the maximum cost amounted to two cents per person insured per month. The findings are based on the extraordinarily low demand for SGDs in any typical insured population. Milliman called the cost *de minimis*, which means "trivial."[8]

To summarize, health insurers and plans have no cost basis and no fact basis to exclude SGDs, so such denials are often unenforceable.

Federal Employee Health Benefits Plan

The United States government is the largest employer in the country. To recruit and retain workers, the government offers workers health insurance benefits. The Office of Personnel Management (OPM) is the agency responsible for overseeing what is known as the Federal Employee Health Benefits Plan, (FEHBP, or simply, FEP). The OPM contracts with private health insurance carriers to provide health benefits to over eight million federal employees, retirees and their dependents. Each year, federal

employees can select from a number of private insurance plans. Plans vary with regard to the design of benefit packages and the cost of premiums to the beneficiary.

Current information. A request is pending with the OPM to void the exclusion of SGDs by primary FEP plans offered by Blue Cross Blue Shield associations.

> Note: Presently, there is an express exclusion in the FEP Blue plan, *http://www.fepblue.org/wasite/wasbp06/wa-sbp06sec5a.html#Anchor-sec5a16.*

The request is based on (1) the Milliman report that shows the insignificance of SGD coverage to the cost of an insurance policy[8] and (2) the fact that the OPM and the FEP policies are subject to Section 504 of the Rehabilitation Act (which prohibits disability-based discrimination in programs funded by, or administered by, the federal government). Updates on the status of this request to OPM will be posted at the *AACFundingHelp* website.

Department of Veterans Affairs

The Department of Veterans Affairs (DVA), formerly the Veterans Administration, offers healthcare benefits to U.S. veterans. These services are provided primarily at a nationwide network of VA hospitals. Each has a prosthetics service, which is the source of SGD coverage within the DVA system. The DVA has covered and provided SGDs since the late 1970's, when they were first introduced into the commercial marketplace.

Tricare

Tricare, formerly known as CHAMPUS (Civilian Health and Medical Program of the United States) is a worldwide healthcare benefits program provided to active duty members of the armed forces and their dependents, and to military retirees and their dependents.

Tricare is administered by the U.S. Department of Defense, through private contractors.

Tricare/CHAMPUS has covered SGDs as prosthetic devices for many years, but coverage was limited only to active duty service members and their dependents. In 2001, Congress authorized Tricare to expand SGD coverage to all program participants. New SGD coverage criteria, modeled on Medicare's, were authorized for all Tricare beneficiaries in 2005.

Special Education

A federal law, known as the Individuals with Disabilities Education Act, or IDEA, entitles every child ages 3 to 21 with a disability to *a free and appropriate education* (FAPE) *in the least restrictive environment* (LRE). An Individualized Education Program (IEP) is the written outline of the student's educational program, which identifies the special education and related services the student will receive. Assistive technology (AT) devices and services are among the wide range of assistance that comprise *special education* and *related services,* and SGDs fit within the definition of an AT device. In fact, the IDEA states that a student's need for AT must be an integral part of the IEP development and review process and must be considered.*** Also, when a student requires AT devices and services to receive a FAPE in the LRE, it is the school's responsibility to ensure the student receives the device and related AT services (*i.e.*, training for the student, the student's parents and school staff to use the SGD).

At a practical level, students with

*** Section 300.308 clarifies that on a case-by-case basis, the use of school-purchased AT devices in a student's home, or other settings, is required if the student's IEP team determines the student needs access in order to receive a FAPE.

complex communication needs (CCN) present three types of issues in an education context.

> 1. Staffing. Who will identify the student's needs, recommend devices and develop and implement treatment plans?

> 2. Clarifying the purpose of an SGD. Is it only to allow students to better communicate in the classroom, or is it to ensure students can meet all daily communication needs using the full range of communication methods that might be effective?

> 3. Funding. Who pays for the SGD and accessories and related services?

To date, there are no standards that address these issues or answer these questions. No entity (*e.g.*, the federal government, state governments or the American Speech-Language-Hearing Association) has developed meaningful guidance for SGD access or for AAC-related services in U.S. schools. Thus, systemic enforcement or oversight is nonexistent and parents are forced to seek their own answers and to compel each school, each year, to provide appropriate AT equipment and AAC services.

The website *AACFundingHelp* will attempt to break this pattern by

> 1. soliciting and posting information about how to develop IEPs that include markers for SGD needs.

> 2. describing needs that can be incorporated into IEPs to ensure that appropriate staff training and parent training occurs.

> 3. describing IEP goals that help ensure SGDs are incorporated into a comprehensive communication curriculum for the student, including making sure SGDs go home with the student and ensuring students who use SGDs have access to extended school year services to maintain their skills.***

> 4. addressing how SGDs can be paid for, either with or without school funding.

Early Intervention

The Program for Infants and Toddlers with Disabilities (Part C of IDEA) is a federal grant program that assists states in operating a comprehensive statewide program of early intervention services for infants and toddlers with disabilities (ages birth through age 2 years) and

their families. In order for a state to participate in the program it must assure that early intervention is available to every eligible child and its family. Also, the governor must designate a lead agency to receive the grant and administer the program, and appoint an Interagency Coordinating Council (ICC), including parents of young children with disabilities, to advise and assist the lead agency. Currently, all states and eligible U.S. territories are participating in the Part C program. The goal is for young children to be as ready as possible to enter school and keep up with their age peers.

The centerpiece of the early intervention process is a planning document—an Individualized Family Services Plan, or IFSP. It identifies functional areas in which the child is not performing at age level and designs services (*e.g.*, medical, rehabilitative, educational) to address them. AT devices and services, including the provision of SGDs and training for the child and family, are available options for children identified as having a severe communication impairment.

Early intervention also has a strong case-management or care coordination component so it can take advantage of every possible source of funding for necessary equipment or services, including any available Medicaid or insurance coverage for SGDs and for SLP assessment and treatment services. If other funding is not available, then early intervention itself is a potential funding source for necessary services.

Vocational Rehabilitation

Vocational rehabilitation (VR) has been a federal program since the early 20th century in the U.S. By offering an array of services designed to enable a person with a disability to acquire or retain employment, it aims to increase the ability of individuals with disabilities to earn income and pay taxes, removing potential dependency on public benefits.

VR is a program outlined in federal law, but administered by the states. Like Medicaid, it requires that individuals with disabilities receive services as outlined on their Individualized Plan for Employment, or IPE (known previously as the Individualized Written Rehabilitation Plan). The VR program recognizes the importance of AT devices (including SGDs) and related services to support a person's ability to work. Another required VR role is to coordinate *transition services* for teenagers with disabilities with the public schools so these students will have the skills, and as appropriate, the equipment they need to meet post-school goals.

Telecommunication Equipment Distribution Programs

The telephone is recognized as an essential tool of modern life that may require *specialized telecommunication equipment* for people with hearing, speech and other disabilities. Telecommunications equipment distribution programs (EDPs) are programs that assist individuals with disabilities to communicate by telephone. These programs can provide SGDs or the funding to obtain this equipment. EDPs do not exist in every state, and not all EDPs cover the same disabling conditions. Almost all, however, recognize that *specialized telecommunication equipment* is needed by individuals with speech impairments.

EDPs obtain funding through small surcharges on monthly telephone service bills. The revenues generated by these surcharges often are split between the EDP and the state's telephone relay service, which primarily aids individuals who rely on TTY or TDD devices or use speech-to-speech relay services. Title IV of the Americans with Disabilities Act mandates relay services, but currently there is no mandate for EDPs. Presently, only about one third of the state EDPs cover and provide SGDs. Most never have been asked.

The results of a recent study by Ball, Golinker and Anderson[9] show that persons with CCN have needs for telephone use that are indistinguishable from those of people without disabilities and that SGDs can make the difference between effective and ineffective telephone communication.

Three legally-significant facts will encourage EDPs to cover SGDs:

1. SGDs are functionally identical to the other items that are typically provided by the EDPs.

2. SGDs facilitate telephone access in a variety of ways.

3. For individuals with speech impairments who require SGDs, there is no alternative means by which to communicate by telephone.

There is no lawful reason for most EDPs to refuse to cover and provide SGDs, and if they refuse, they are violating Title II of the ADA (discrimination on the basis of disability).

Note: The AACFundingHelp website provides more information about EDP programs.

AAC-RERC
SPREAD THE WORD

On the Web

www.aacfundinghelp.com

The AAC community shares funding and advocacy information through conference sessions, articles, websites, manufacturers' staff, teleconferences, video-teleconferences and webcasts. Even so, it is often hard to access and may be out-of-date when you need it. That is why Lewis Golinker launched a new website devoted to AAC device funding. The site *www.aacfunding help.com* is a joint effort of Golinker's Assistive Technology Law Center, Duke University and the AAC-RERC.[2] Currently, it focuses on the United States, but sections devoted to AAC device funding in Canada and England are planned for 2007. Golinker states,

> The goal of the AACFundingHelp site is to be recognized as having its C's— to be Comprehensive, Credible and Current.[10]

The site is a one-stop source for information about SGD funding for professionals, people with complex communication needs (CCN), their families, staff of funding programs and AAC advocates. The site has four sections:

SGD Funding Fast Facts: Information about the need and demand for SGDs, SGD costs to funding programs, a history of SGD funding, SGD coverage vocabulary, and why SGDs are medically necessary.

SGD Funding Programs: Information about the ten largest public and private third-party benefits programs that cover and provide funding for SGDs. *See Clinical News* in this issue.

AAC Report Coach: An on-line tool to guide speech-language pathologists (SLPs) through the process of writing an SGD funding request report developed by Dr. Pamela Mathy.[11]

SGD Funding General Resources: Information about insurance codes for SGDs and current fee schedules. Letters from the American Medical Association, American Academy of Neurology and American Academy of Physical Medicine and Rehabilitation acknowledging the effectiveness and medical need of SGDs.

Presently, the most complete discussions on the site relate to Medicare. Additional content related to other programs will be posted in 2007. AAC-RERC

SPREAD THE WORD

Governmental

Funding Around the World

I asked some colleagues to give me a sense of funding issues for SGDs and AAC services in different parts of the world. While NOT an authoritative survey, the results show that some nations are making great progress while others are just beginning. See Table III on page 8.

Australia. All six Australian states have AT funding programs and offer some funding for SGDs.[12] The programs are administered by state government authorities (*e.g.*, New South Wales Health & Area Health Services, the Department of Human Services, Disability Services Commission, Queensland Health, Disability Services SA and the Department of Health and Human Services). Each program has different eligibility criteria and guidelines for procuring SGDs. Some, Victoria for example, provide devices on loan. Philanthropic funding is often required in addition to government funding because most funding agencies have an upper limit for device funding. Other funding sources for SGDs include state education and commonwealth rehabilitation programs.

Canada. For the most part, Canada's ten provinces offer AAC services and funding for SGDs.[12] In addition, some funding may be available through three federal programs:

(1) Health Canada - First Nations and Inuit Health: Non-Insured Health Benefits
(2) Veterans Independence Program
(3) Opportunities Fund for Persons with Disabilities.

A brief description of four of the provincial programs follows.

Ontario. A network of over 20 AAC Clinics provide AAC services for children and adults and prescribe SGDs. The Ministry of Health offers equipment funding at 75% of the cost of the equipment unless the individual receives social assistance and then it provides 100% funding. Leasing and changing equipment are also options.

British Columbia. The Ministry of Education offers funding for SGDs. Funding recently expanded to include children and young adults up to 29 years old. Loaned equipment is also available.

Alberta. *Alberta Aids to Daily Living* is administered through the Department of Seniors and Community Supports and modeled loosely on Ontario's AT technology program. Two centers (one in Calgary and one in Edmonton) conduct multidisciplinary AAC evaluations. Persons across the age span with CCN are eligible for funding. There is a $500 annual co-payment aggregated for all assistive technology.

Quebec. Those attending school obtain SGDs through the Ministry of Education. Those not in school receive long-term loans from an SDG device bank from the Ministerial Program for Communication Aids. For people with degenerative diseases, such as ALS, devices can be approved in a few days. Requests go through a committee of experts who meet regularly.

Table III. Answers to three questions about funding in different countries			
Country	**Question #1**	**Question #2**	**Question #3**
	How are most AAC devices funded in your country? Has this changed over the past 10 years?	Is a lack of funding for AAC devices a major barrier? If so, what future solutions can you foresee?	AAC devices and AAC services they need?
Australia Meredith Allan Susan Balandin Hilary Johnson	Each state now has an equipment program (including AAC devices) for people with disabilities. Age, eligibility requirements, *etc.* differ widely and additional philanthropic funding is often required. Access to loan equipment for children has also improved.	Equipment costs are increasing. It can be difficult to try equipment to make sure it will work. Also, a lack of funding for communication aids and services, particularly in preschool, is limiting the early language development of children. Children need access to services to support AAC use.	Costs of devices, services and repairs are high. A lack of knowledge on the part of individuals with CCN, their family members and professionals is a barrier. Actual training in the use of devices is still limited so people who get devices may not learn to use them well.
Canada Albert Cook Shelley Deegan Catherine Dench	Funding for AAC devices varies. Provinces with the largest concentration of the population now have both AAC services and funding for AAC devices. However, each province has specific eligibility requirements, procedures, *etc.*	Even though access to SGDs has improved over the past 10 years, not everyone who needs an AAC device and AAC services can get what they need. [Note: A goal of ISAAC-Canada is to ensure AAC services and funding is available across the country.]	People in more isolated regions of the country may get equipment, but they have greater difficulty getting AAC services. There is an effort to provide more training to isolated areas (teleconferences/video training, *etc.*) and to help people with CCN to access Centres of Expertise.
Mexico Gaby Berlanga	AAC is just emerging in Mexico. Many people don't even know about AAC devices. Funding is a difficult issue. There are no insurance or government programs that pay for AAC services or AAC devices.	Funding is a major barrier. In Mexico City, for example, many people could benefit from an AAC device (*I am sure it would change their lives*), but there is no funding or even a way to try using an AAC device. People need more information about AAC.	We have a lot of work to do, but we're beginning and there is much more interest. Many still believe that AAC interferes with the development of speech and other myths. Raising awareness and sharing information is important for us.
South Africa Erna Alant	Most AAC devices are funded through a combination of private individuals and medical aids. The use of AAC devices has not increased because financial supports are so limited.	Financial support is a major limitation - not only for devices, but also for AAC services. Education and Health departments in the government are considering funding simple digital voice output devices.	The HIV/AIDS pandemic and the lack of an organised disability movement means we are not influencing policy makers and funders. There is also a lack of expertise in doing AAC intervention that we are working to improve.
United Kingdom Caroline Gray Janet Larcher James Rowe	Until April 2006, the Communication Aids Project (CAP) funded equipment and training for school age children in England (not Scotland or Wales). Currently, there are no regional or national strategies. Each educational and health authority has its own policy on funding. Identifying funding sources for children and adults demands time and energy.	Lack of funding is a major barrier to many people. There are currently two groups pushing to establish a funding route for people of all ages. This involves establishing models of good practice for assessment, training and provision of devices and involves people from government ministries (Health, Education, Social Services, Trade and Industry, and the Office of Disability Issues). There is a concerted push from the grass roots as well.	Having increased the amount of equipment in use and peoples' expectations of what can be achieved, there is now insufficient funding for training, support, repair and upgrading of existing equipment, as well as provision for new AAC users.

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[2] Developed by Lewis Golinker with support from the Assistive Technology Law Center, Duke University and the AAC-RERC.

[3] Lewis Golinker (November 22, 2006). Personal communication.

[4] Medicare Guidelines for SGDs are reprinted and extensively reviewed at http://www.aac-rerc.com.

[5] http://www.aacfundinghelp.com (*Funding Programs Medicare*).

[6] Manufacturers' websites have information about Medicaid requirements for SGD requests in each state. For links, go to http://aac.unl.edu/AACVI1.html.

[7] http://www.aacfundinghelp.com (*Funding Programs Insurance Benefits Database*).

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