

Wheelchair Positioning Evaluation and Prescription Form

Date: _____ Beneficiary Name: _____ DOB: _____

Address: _____ Phone: _____

_____ Contact Person: _____

Insurance(s): _____ Policy #: _____

Medical Conditions (include onset dates): _____

_____**FUNCTIONAL LEVELS**

Bed Mobility: _____

Transfers (technique, assist level): _____

Ambulation (distances, devices, assist): _____

Propulsion technique (specify equipment, limbs used): _____

_____**(Over 21 only):**

- Check the **mobility related activities of daily living (MRADLs)** that cannot be accomplished without the requested device. Feeding Dressing Grooming Bathing
- Check the nature of the **mobility limitation** that significantly impairs the ability to participate in MRADL activity:
 - Prevents the accomplishment of the MRADL
 - Places the patient at reasonably heightened risk of morbidity or mortality in the attempt to perform MRADL
 - Prevents completion of the MRADL in a reasonable time frame.
- Check if the beneficiary is unable to access authorized medical transportation to medical services without the requested device.
- Check if the beneficiary **can not** functionally ambulate within the home environment and/or a radius of 100 feet.

Comments: _____

_____**MEDICAL STATUS**

Medications: _____

Cardiovascular/Pulmonary: _____

Sensory (vision, hearing, tactile): _____

Musculoskeletal: _____

Neurological (inc. seizure): _____

Cognitive: _____

Communication: _____

Integumentary: _____

PSYCHOSOCIAL

School/employment: _____

Transportation system to medically necessary appointments: _____

Transported in w/c to medically necessary appointments? Yes No

Prescribed chair fits into transportation to medically necessary appointments? Yes No

Ramp slope into van: 1:12 (4.5 degree) 1:10 (6 degree) 1:8 (7.5 degree) 1:6 (9 degree) N/A
 Other _____

Head clearance into vehicle (with tilt if applicable): Yes No

Method of chair transport (ex: car topper, fold in rear seat, transit brackets): _____

Home entry/exit (ramp slope, stairs): _____

Terrain to medically necessary transportation (distance, condition including obstacle heights, all seasons): _____

Terrain within 100 feet of home (condition including obstacle heights, all seasons): _____

Threshold height and floor conditions: _____

Ramp slope into home: 1:12 (4.5 degree) 1:10 (6 degree) 1:8 (7.5 degree) 1:6 (9 degree) N/A
 Other _____

Turning radius needed in home: _____

Turning radius of wheelchair: _____

Door width: exit: _____ bedroom: _____ bathroom: _____

Width of prescribed chair: _____

Is the chair suitable for use in the home environment? (**Over 21 only**) Yes No

If not, explain extenuating circumstances: _____

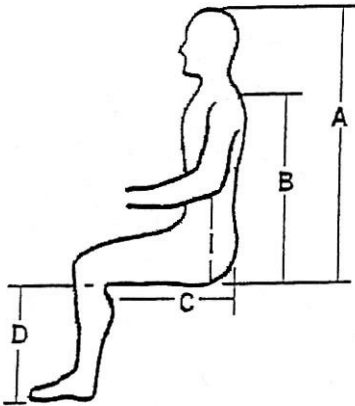
Terrain at and surrounding school/employment and community (**Under 21 only**): _____

Community transportation (**Under 21 only - ex: school bus**): _____

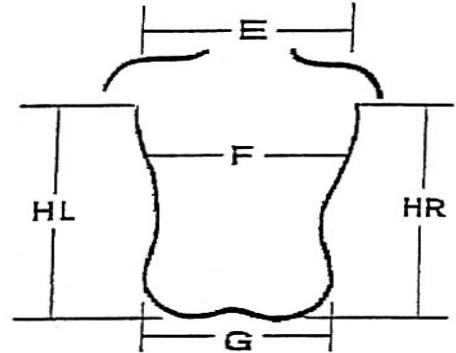
MEASUREMENTS

Height: _____

Weight: _____



A _____	F _____
B _____	G _____
C _____	HR _____
D _____	HL _____
E _____	I _____



MUSCULOSKELETAL EVALUATION

	L	R
ROM/strength:		
hip flexion	_____	_____
hip abd.	_____	_____
hip add.	_____	_____
hip internal r.	_____	_____
hip external r.	_____	_____
knee ext.	_____	_____
knee flex.	_____	_____
ankle DF	_____	_____
other_____	_____	_____

Mobility related issues:

Trunk: _____

Pelvis: _____

Upper extremity: _____

Head control: _____

Sitting balance: _____

WHEELCHAIR PRESCRIPTION:

Wheelchair Components:

Base: (Check one)

Manual wheelchairs:

- Standard
- Standard hemi height
- Lightweight
- High strength, lightweight
- Ultra-lightweight
- Heavy duty
- Extra heavy duty
- Tilt in space
- Recliner, full
- Recliner, semi
- Pediatric wheelchair/stroller

Power Operated Vehicles:

- Group 1
- Group 2

Power Wheelchairs:

- Group 1
- Group 2
- Group 3
- Group 4
- Group 5

Options - Power Wheelchairs:

(Check all that apply)

- Elevating leg rests
- Power tilt
- Power recline
- Other: _____

Wheelchair Components and Medical Necessity Justification

Frame size: _____

Back: _____

Seat: _____

Arm: _____

Front rigging: _____

Drive wheels: _____

Casters: _____

Wheel locks: _____

Interface (power chair): _____

Electronics (ex: controllers, power seating functions): _____

Other: _____

Assembly instructions: _____

Seating Components and Medical Necessity Justification

Seat (including cushion): _____

Back (including cushion): _____

Trunk _____

Head: _____

Upper extremity: _____

Lower extremity: _____

Other: _____

Cost Comparison:

Medicaid requires that there be coverage for the least expensive, medically necessary device ([7102.2](#)). Document that EACH lesser device was considered/trialed and deemed not medically appropriate for the recipient; provide rationale:

Cane/Crutches: _____

Walker: _____

Manual wheelchair (if requesting power device): _____

Lesser manual wheelchair (if requesting a manual device): _____

Power operated vehicle (scooter) (if requesting power wheelchair): _____

Lesser Group Power wheelchair: _____

SIGNATURE SHEET

Vendor and Therapist Acknowledgement (Please initial each statement):

Vendor Therapist

I have researched, and have not found, any less costly wheelchairs or components that would be appropriate to the individual's medical needs at this time. Any components from the individual's current wheelchair that can be utilized will be placed on the new wheelchair.

I have explained to the beneficiary that, should any defects develop in the device, the beneficiary must report the defects to the vendor.

I have explained to the beneficiary that the expectation is that this wheelchair will last for at least 5 years, and should be treated so that it will last for at least 5 years. If there is a change in the beneficiary's size and/or condition, consideration can be given to coverage of wheelchair/components sooner than 5 years.

I have instructed the individual/caregivers on safe home and vehicle entry and exit with the wheelchair, or will provide this information at the time of the wheelchair fitting.

I have explained to the individual/caregivers proper operation of the wheelchair, or will provide this information at the time of the wheelchair fitting.

I have explained to the beneficiary that should the chair no longer fit or no longer be needed, that it is the property of Medicaid and should be returned to Medicaid; and to call the phone number on the sticker placed on the device.

(Over 21 only): From the measurements provided in this prescription, I have determined that the wheelchair will fit in the beneficiary's mobility-related ADL environment which includes 100 feet beyond the home itself, and is suitable for use therein; that it is required to perform one or more mobility related activities of daily living (feeding, grooming, dressing, and hygiene) and/or to perform medically necessary access to medical care, and fits into the primary transportation device that brings the beneficiary to medically necessary medical care.

Beneficiary/Legal Guardian Acknowledgement (please initial each statement):

I accept the specific wheelchair and/or components being requested on my behalf in this prescription.

I have had an opportunity to try the wheelchair or a simulation so that I know it will work for me and fit properly in my home.

I understand how to properly care for and maintain the device so that it can last for at least 5 years OR understand that I will receive this information at the time of the wheelchair fitting.

I understand that the wheelchair is expected to last at least 5 years, and I will treat it so that it will last for at least 5 years. I understand that if I have a significant change in size or condition, that consideration will be given to coverage of wheelchair/components sooner than 5 years.

I understand that the device is the property of Medicaid. If it is no longer medically necessary, I understand that I should call the number on the sticker that will be placed on the device.

I understand how to properly operate the wheelchair, or understand that I will receive this information at the time of the wheelchair fitting.

(Over 21 only): I require this device to accomplish one or more mobility related activities of daily living (feeding, grooming, dressing, and hygiene) and/or to access medically necessary medical care.

(Over 21 only): The device fits in my mobility related ADL environment which includes 100 feet beyond the home itself, and in the transportation I use to get to medically necessary medical care.

Comments: _____

All parties signed below deem this prescription accurate and medically appropriate:

Date	Name (please print)		Signature
		Client or legal guardian	
		Physician	
		*Therapist	
		**Supplier	

*Therapist, include your professional designation (PT, OT)

**Supplier, include your ATP status for wheelchairs requiring ATP certification.

