

## SIGNATURE SHEET

December 2015

**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 medical condition, consideration can be given to coverage of wheelchair/components sooner than 5 years. I have explained that Medicaid covers the cost of medically necessary repairs so that the device will continue to operate properly and safely for at least 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 safe 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 that has been placed on the device.
		I have explained to the beneficiary that, should the device be lost or stolen, a police report must be submitted with any request for replacement of the device.
		<b>(Over 21 only):</b> 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 provide 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 check or 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 medical condition,

	that consideration will be given to coverage of wheelchair/components sooner than 5 years. I understand that Medicaid covers the cost of medically necessary repairs so that the device will continue to operate properly and safely for at least 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.
	I understand that if the device is lost or stolen, a police report must be submitted with any request for replacement of the device.
	<b>(Over 21 only):</b> 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.
	<b>(Over 21 only):</b> The device fits in my mobility related ADL environment which includes my home, 100 feet beyond the home itself, and in the transportation I use to get to medically necessary medical care.

Comments:

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**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.