VERMONT

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Agency of Human Services

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Wheelchair Positioning Evaluation and Prescription Form

Complete this form entirely. Leave no spaces blank. Missing information will result in delays and denials.

March 2017

Date: _____ Beneficiary Name: _____ DOB: _____

Beneficiary Address: _____

Evaluator Name: _____

Evaluator phone: _____

Evaluator email: _____

Evaluator facility:_____

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(s).
  - ☐ Places the patient at reasonably heightened risk of morbidity or mortality in the attempt to perform MRADL(s).
  - ☐ Prevents completion of the MRADL(s) 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 **cannot** 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: _____

_____

If a personally owned vehicle and assistance is required for securing the wheelchair, are there consistent care providers available? ☐ Yes ☐ No ☐ N/A

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

If the chair will be used as a seat during transport:

- Is there access to the structural frame of the wheelchair? ☐ Yes ☐ No ☐ N/A
- Are there components that interfere with the utilization of the wheelchair frame for securing the chair in the vehicle? ☐ Yes ☐ No ☐ N/A Explain:

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 Visit Information:

Note that home visits performed by the prescribing therapist are **strongly** recommended, to ensure that the requested device is appropriate for the MRADL(s) environment.

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

Terrain to medically necessary transportation (distance, condition including obstacle heights, seasonal conditions):_____

_____

Terrain within 100 feet of home (condition including obstacle heights, seasonal conditions): _____

_____

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):** _____

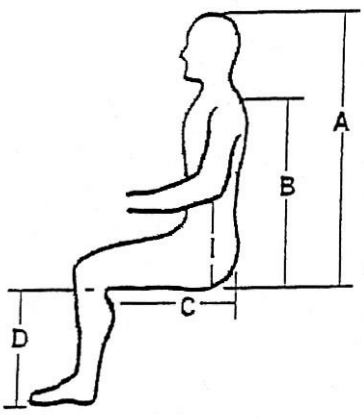
_____

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

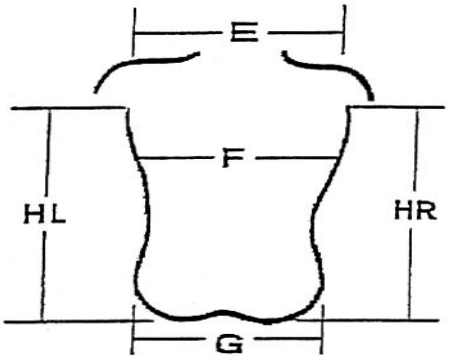
_____

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: _____

Postural influences (tone, reflexes): _____

Current Mobility Equipment:

Type: _____

Age: _____

Condition: _____

Previous coverage source: _____

Assessment: (You may also attach clinic note and supporting documentation.) _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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: _____

Medical necessity justification for the type of base chair requested: _____
_____

Wheelchair Components: Provide Medical Necessity Justification for each component
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: Provide Medical Necessity Justification for each component
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 (Medicaid Rule 7102.2). Document that EACH of the following devices were 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: _____

_____