

### SIGNATURE SHEET

July 2019

**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 maintenance and repairs so that the device will continue to operate properly and safely for at least 5 years.
		I have explained to the beneficiary/caregivers how to keep the wheelchair clean and functioning properly. If it is a powered device, I have explained how to properly place and use the charger.
		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: allow access to mobility related ADLs (feeding, grooming, dressing, and hygiene) in or outside of the home; allow access to medical care; allow access to authorized Medicaid transportation to medical services; and allow exit from the home within a reasonable time frame.
		<b>For all wheelchairs that require Assistive Technology Professional (ATP) presence during the wheelchair scripting process:</b> (including Group 2 power wheelchairs with single or multiple power options; all Group 3, Group 4 and Group 5 power wheelchairs; power assist; ultralightweight manual wheelchairs; and tilt-in-space manual wheelchairs) I guarantee that the ATP and the prescribing therapist will be present at the fitting to ensure that the wheelchair and seating fit and function properly. If the prescribing therapist cannot be present, then a therapist who is knowledgeable regarding proper seating, who is familiar with the beneficiary or who has been provided the evaluation and prescription documentation, may substitute for the prescribing therapist.

**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 the places where I go to perform my mobility related activities of daily living (feeding, grooming, dressing, and hygiene).
	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. If the device is a powered device, I have been instructed in where to place the charger and how to use it properly.
	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 (MRADLs:feeding, grooming, dressing, and hygiene), to access medically necessary medical care, and/or to be able to exit the home in a reasonable time frame.
	<b>(Over 21 only)</b> The device fits in my mobility related ADL environment and in the transportation I use to get to medically necessary medical care.
	<b>For all wheelchairs that require Assistive Technology Professional (ATP) presence during the wheelchair scripting process:</b> (including Group 2 power wheelchairs with single or multiple power options; all Group 3, Group 4 and Group 5 power wheelchairs; power assist; ultralightweight manual wheelchairs; and tilt-in-space manual wheelchairs) I understand that I will be fitted to my wheelchair by an ATP from my equipment provider's office and by either the prescribing therapist or a therapist who knows my seating needs and is knowledgeable about seating.

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, physician assistant, nurse practitioner, or clinical nurse specialist	
		*Therapist	
		**Supplier	

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

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