VERMONT

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Agency of Human Services

Wheelchair Positioning Evaluation and Prescription Form

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

Date: ___/___/____ Beneficiary Name: _____ DOB: ___/___/_____

Beneficiary Medicaid Number: _____ Beneficiary Address: _____

Evaluator Name: _____

Evaluator Phone: _____

Evaluator Email: _____

Evaluator Facility: _____

Insurance(s): _____ Policy #: _____

Medical Conditions (include onset dates): _____

_____

_____

Wheelchair evaluation referral date: (this is the date the referring provider first requested a wheelchair evaluation): ___/___/____

FUNCTIONAL LEVELS

Bed Mobility: _____

Transfers

Technique: _____

Assist Level: _____

Ambulation:

Distance: _____

Devices: _____

Assist:_____

Propulsion technique

Limbs used: _____

Equipment needed: _____

(**Over 21 only**):

Check the **mobility related activities of daily living (MRADLs)** that cannot be accomplished without the requested device.

☐ Feeding ☐ Dressing ☐ Grooming ☐ Bathing ☐ Hygiene (toileting)

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 environments in which MRADLs are performed

Comments: _____

_____

_____

_____

MEDICAL STATUS

Medications: _____

Cardiovascular/Pulmonary: _____

Sensory (vision, hearing, tactile): _____

Musculoskeletal: _____

Neurological (including 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 wheelchair 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 utilizing 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 (e.g. car topper, fold in rear seat, transit brackets):

_____

_____

HOME VISIT INFORMATION

Home visits performed by the prescribing therapist, either in person or via telemedicine, 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: _____ Conditions: _____

Obstacle heights: _____ Slope: _____

Seasonal conditions: _____

Threshold height: _____ 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: _____

Distances to exit: _____

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):**

_____

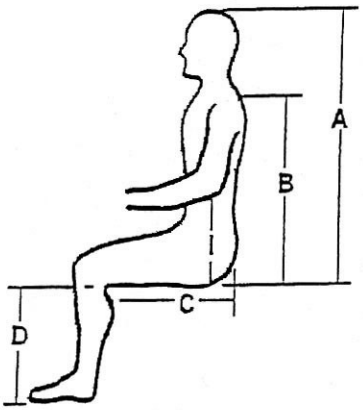
Community transportation **(Under 21 only – e.g. school bus):**

_____

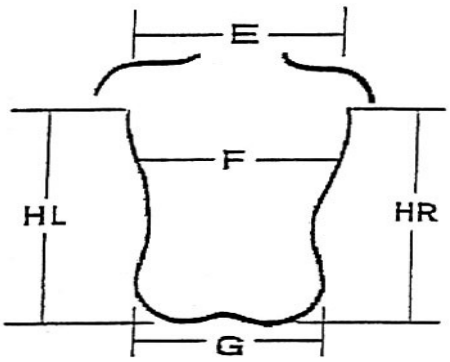
_____

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: _____

Plan for disposal of the previous device if the requested device is authorized:

_____

_____

_____

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: _____

Wheelchair and Components: (provide medical necessity justification for each component)

Component	Specifications	Medical Necessity Justification
Base Chair: review definitions in the Appendix (see wheelchair packet)		
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)

Component	Specifications	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 (Medicaid Rule 7102.2). Document that EACH of the following devices were considered/trialed and deemed not medically appropriate for the recipient. Please 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: _____