

Medical Necessity For Wheelchair Purchase For Nursing Facility (NF) Clients

Fax number: 1-866-668-1214

NOTE: The small numbers coordinate with the instructions. **Do not alter this form in any way.**

(2) **All spaces MUST be completed by the Physical/Occupational Therapist within 60 days of request.**

CLIENT NAME	CLIENT ID	(2) RX ON FILE YES <input type="checkbox"/> NO <input type="checkbox"/>
NURSING FACILITY (IF APPLICABLE)		
THERAPIST NAME		FAX NUMBER
<p>(3) Diagnosis/Specific /Disabilities as applies to requested equipment including relevant degree of contractures and history of pressure wounds with dates, site, and stage.</p> 		
(4) INDICATE IF APPLICABLE <input type="checkbox"/> Scoliosis <input type="checkbox"/> Kyphosis Degree of curvature _____		PATIENT HEIGHT (INCHES)
		PATIENT WEIGHT (LBS.)
LOWER LEG LENGTH (INCHES)	UPPER LEG LENGTH (INCHES)	HIP WIDTH MEASUREMENT (INCHES)
<p>(5) What is the anticipated length of use of this equipment in mouths and/or years? _____</p> <p>Please describe the client's ambulation status and limitations:</p> <p>Does the client use mobility aids (crutches/walker)? Yes <input type="checkbox"/> No <input type="checkbox"/> Distance client ambulates in feet: _____</p> <p>What is the client's transfer status?</p>		
PLAN OF USE: Full time, exclusive, permanent? Yes <input type="checkbox"/> No <input type="checkbox"/>		HOURS PER DAY
<p>(6) MANUAL wheelchair – can client effectively, independently, without cues propel the wheelchair? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes, number of feet propelled at one time in the requested wheelchair: _____</p> <p>Does client propel with: <input type="checkbox"/> arms <input type="checkbox"/> feet <input type="checkbox"/> both</p> <p>POWER wheelchair – can client safely utilize/drive the chair? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes, number of feet at one time: _____</p> <p>If a power wheelchair is requested, tell us why the client is unable to operate a manual wheelchair.</p> <p>Will client be driving the power wheelchair independently in the community, outside the facility? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Will a caregiver be required to accompany the client? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>For what purpose will the client be in the community? _____</p> <p>How many hours per day/week? _____</p>		

Indicate client specific medical justification for each of the following: (Photos and or videos are helpful)

(7) MAKE AND MODEL OF EQUIPMENT

(7 A-F) All Accessories and Modifications: (You may submit additional attachments)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

DOES CLIENT CURRENTLY OWN A WHEELCHAIR? Yes <input type="checkbox"/> No <input type="checkbox"/>	IF YES, <input type="checkbox"/> Manual <input type="checkbox"/> Power	PURCHASE BY <input type="checkbox"/> Private <input type="checkbox"/> DSHS <input type="checkbox"/> Donated	DATE PURCHASED
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APPROXIMATE AGE	MAKE	MODEL NUMBER	SERIAL NUMBER
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Does client's current wheelchair meet his/her medical needs? Yes No

(8) If the client's current wheelchair does not meet the medical need, why not?

(9 and 10) PHYSICAL/OCCUPATIONAL THERAPIST'S SIGNATURE	DATE
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(11) PRESCRIBING PHYSICIAN'S SIGNATURE	DATE
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INSTRUCTIONS

1. All spaces must be completed, by the Physical/Occupational Therapist.
2. RX on file means: You must have a physician's prescription in the client's file for any a) new equipment, or b) new accessories on existing equipment
3. List only those diagnoses and disabilities that apply to the equipment being requested.
4. The information regarding Scoliosis and Kyphosis must be completed when a custom back or wheelchair with tilt-in-space or recline feature is being requested.
5. Indicate length of use in months and/or years. General statements, such as *lifetime* and *indefinite* are not acceptable.
6. When indicating how far the client can independently propel the wheelchair, indicate as applies to the equipment being requested.
7. The make/model of wheelchair and each accessory/modification requested must be justified separately. You may use the lines on the physical therapy evaluation form or you may submit an additional attachment listing each item and the medical necessity for them.

The following information is necessary when justifying the equipment and accessories:

- A. Indicate what other less expensive alternatives have been tried or considered and why they will not meet the client's medical needs.
 - B. All justifications must be client specific General statements as to standards of care or industrial standards for generalized equipment use are not appropriate to justify specific equipment needs.
 - C. When requesting a specialized back or a wheelchair with a tilt-in-space or recline feature, indicate the degree of curvature requiring the modification (e.g. Scoliosis, Kyphosis or Lordosis).
 - D. Indicate if the client has excessive extensor tone/muscle spasticity of the trunk/upper body muscles requiring support or impacting the degree of hip flexion/extension.
 - E. For specialized cushions, indicate what other cushions have been tried, what the documented outcome was and the length of trial or what other cushions were considered and why they will not meet the client's medical needs. Also document if client has an existing decubitus and if so what the stage is. If the client has a history of decubitus, indicate dates, stage, site and duration.
 - F. Indicate if the client has any musculoskeletal conditions, cast or brace that prevents 90-degree flexion of the knee or hip.
8. If the already owns a wheelchair, and new wheelchair is being requested, indicate the medical reasons the existing wheelchair no longer meets the client's needs. Indicate if it can be repaired or modified to meet the client's needs and if not, why not. If the chair can be repaired or modified to meet the client's needs, the vendor supplying the equipment will need to submit a cost comparison for repairs vs. purchase.
 9. The Physical/Occupational Therapist's signature and date goes on this line. HRSA must receive this form within 60 days from the date placed on this line.
 10. Once a therapy evaluation is on file with DSHS for the client, it is valid for 1 year to allow for repairs. A new therapy evaluation will be required after 1 year has lapsed.
 11. The prescribing physician must sign the evaluation before submittal to DSHS.