

Mobility and Seating Evaluation and Justification Completion Instructions

This form should be completed for NEW or REPLACEMENT mobility device and seating systems. It must be submitted with the Special Services Prior Approval -Request/Authorization (MSA-1653-B). The evaluation and justification must be submitted within 90 days of the date the form is completed.

BENEFICIARY INFORMATION: Complete beneficiary name, date of birth, sex of beneficiary, beneficiary mihealth number, treating physician, physician specialty and other insurance. The beneficiary name and mihealth number must be entered at the top of each page.

SECTION 1 THROUGH SECTION 14 MUST BE COMPLETED BY A LICENSED MEDICAL PROFESSIONAL. In each section, check the boxes and supply the information requested as it applies to the beneficiary.

NOTE: A licensed medical professional means an occupational or physical therapist or rehabilitation RN who has at least two years' experience in rehabilitation seating, and is not an employee of or affiliated in any way with the Medical Supplier with the exception of hospitals with integrated delivery models that include the supplier of the equipment and the provider of the clinical evaluation. (PTAs and OTAs may not evaluate for, complete or sign this document.)

| SECTION | INSTRUCTIONS |
|---------|---|
| 1 | Indicate the beneficiary resides in a nursing facility, permanent legal address, telephone number, designated contact person for the beneficiary, designated person's (i.e., parent, guardian, legal representative or beneficiary) telephone number, date and time seen, evaluator name and title, date, evaluator phone number and evaluator's place of employment. If team evaluation lists participants and titles. |
| 2 | Medical history is used to gather information in regards to the beneficiary's physical status and progression of disease. Estimate weight if unable to weigh at time of evaluation. |
| 3 | Home Environment questions reflect the current setting in which the beneficiary lives. |
| 4 | Community Activities of Daily Living (ADL) reflects the beneficiary's transportation situation to the community and/or school if applicable. |
| 5 | This information reflects the need for pressure relief for a beneficiary. |
| 6 | ADL Status reflecting the beneficiary's current functioning. |
| 7 | The communication section indicates if a speech generating device is utilized by the beneficiary and needs hardware attached to the wheelchair. |
| 8 | Wheelchair skills indicate how the beneficiary could operate various types of wheelchairs. |
| 9 | Mobility/Balance reflects the current ambulation, sitting and standing status of the beneficiary. |
| 10 | Power mobility safety relates to the beneficiary's abilities to safely operate a power mobility device. Definitions : Good-(FIM level7/6), completes tasks by self; Fair-(FIM level 5), requires verbal cues; Poor-(FIM level 4 and below), requires physical intervention/assistance to complete task. |
| 11 | Current mobility/seating supplies information regarding the current wheelchair seating system the beneficiary uses. |
| 12 | Mat Evaluation includes measurements of the beneficiary. Relevant measures include adjustments for clothing. |
| 13 | This section is to address the beneficiary goals for the wheelchair mobility and seating system. This also includes other equipment trials of which three other types have been given a trial with the reasons those were not adequate. |
| 14 | To be completed by the licensed medical professional who completed the evaluation. The signature certifies the information is applicable to the named beneficiary. |
| 15 | <p>To be completed by the supplier. Supplier gives a narrative description of the items, accessories and options ordered along with the appropriate Healthcare Common procedure Coding System (HCPCS) code, modifier and quantity. The supplier also lists the charge for each item, accessory or option. The person from the Medical Supplier Company lists their name along with the name, telephone number and address of the supplier. There are two sections to accommodate entries by two separate providers for the requested equipment.</p> <p>Note: For beneficiaries residing in a nursing facility return the completed MSA-1656 and MSA-1653-B, to the requesting nursing facility. For beneficiaries in the community the MSA-1656 and MSA-1653-B is forwarded to the treating physician for their review and attestation.</p> |

| SECTION | INSTRUCTIONS |
|---------|---|
| 16 | <p>To be completed by the nursing facility director of nursing, administrator or treating physician.</p> <ul style="list-style-type: none"> ➤ Forward to the treating physician for their review and attestation. ➤ After section 17 is completed and returned. Send along with the most recent MDS, past two months of nursing notes, and current care plan to for their completion of the order. |
| 17 | <p>To be completed by the treating physician. The treating physician reviews the evaluation and the ordered equipment and costs and certifies the equipment is appropriate and most cost effective alternative for the beneficiary.</p> |

SUBMIT TO:

**Michigan Department of Community Health
Program Review Division
PO Box 30170
Lansing, Michigan 48909**

Fax: (517) 335-0075

Authority: Title XIX of the Social Security Act.
Completion: Is Voluntary, but is required if payment from applicable program is sought.

Michigan Department of Community Health is an equal opportunity employer, services and programs provider.

Mobility and Seating Evaluation and Justification

Sections 1-14 must be completed by a licensed medical professional.*

Section 15 is to be completed by the DME Provider.

Section 16 must be completed by the Nursing Facility DON, Administrator, or treating physician.

Section 17 must be completed by the treating physician.

| Beneficiary Information | |
|-------------------------|--|
| Beneficiary Name: | _____ |
| Date of Birth: | _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F |
| mihealth #: | _____ |
| Treating Physician: | _____ |
| Physician Specialty: | _____ |
| Other Insurance: | _____ |
| | _____ |

SECTION 1: BENEFICIARY ADDITIONAL INFORMATION

| | |
|---|------------------------------------|
| Beneficiary resides in Nursing Facility? <input type="checkbox"/> YES <input type="checkbox"/> NO | Evaluation date: _____ Time: _____ |
| Beneficiary address: _____ | Evaluator name: _____ |
| _____ | Title: _____ |
| Beneficiary phone: _____ | Date: _____ Phone: _____ |
| Designated contact person: <i>(i.e., parent, legal guardian, legal representative or beneficiary)</i> | Place of Employment: _____ |
| _____ | _____ |
| Contact person phone: _____ | |
| If team evaluation, list all participants: | |
| _____ | |
| _____ | |

SECTION 2: MEDICAL HISTORY

| | |
|--|---|
| Primary Diagnosis: _____ | Secondary Diagnosis: _____ |
| Onset date: _____ | Onset date: _____ |
| ICD-9-CM Code: _____ | ICD-9-CM Code: _____ |
| Progressive Disease: <input type="checkbox"/> YES <input type="checkbox"/> NO | Relevant past and future surgeries: _____ |
| Other Service - Hospice: <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| Height: _____ Weight: _____ | Explain recent changes or trends in weight: _____ |
| Cardio Status: (Check) <input type="checkbox"/> Intact <input type="checkbox"/> Impaired <input type="checkbox"/> N/A | Functional Limitations: _____ |
| Respiratory Status: (Check) <input type="checkbox"/> Intact <input type="checkbox"/> Impaired <input type="checkbox"/> N/A | Functional Limitations: _____ |
| Orthotics (describe): _____ | |

SECTION 3: HOME ENVIRONMENT

| |
|---|
| Does beneficiary reside in: <input type="checkbox"/> House <input type="checkbox"/> Condo/town home <input type="checkbox"/> Apartment <input type="checkbox"/> Assisted Living <input type="checkbox"/> Nursing Facility |
| <input type="checkbox"/> Adult Foster Care (AFC) <input type="checkbox"/> Group Home |
| Does beneficiary live alone? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Does beneficiary have a caregiver? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, how many hours with caregiver? _____ |
| Is the home wheelchair accessible for the beneficiary? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Storage of Wheelchair: <input type="checkbox"/> In home <input type="checkbox"/> School <input type="checkbox"/> Other |
| Comments: _____ |

*A licensed medical professional means an occupational or physical therapist or rehabilitation R.N. who has at least two (2) years experience in rehabilitation seating and is not an employee of the Medical Supplier. (PTAs and OTAs may not evaluate for, complete or sign this document.)

Beneficiary Name: _____

mihealth Number: _____

SECTION 4: COMMUNITY ADL

Transportation:
 What is beneficiary's **mode** of transportation? (Check all that apply.)
 Car Van Cab Bus School Bus Ambulance Other: _____
 Are tie-downs needed for transport? YES NO
 Where is wheelchair stored during transport? _____
 Is beneficiary a self driver? YES NO If YES, do they drive while in wheelchair? YES NO
 Does beneficiary attend school? YES NO
 If YES, provide name of school: _____
 List school mobility requirements: _____
Other: _____

SECTION 5: SENSATION AND SKIN ISSUES

| | | |
|---|---|---|
| Sensation <input type="checkbox"/> Intact <input type="checkbox"/> Impaired <input type="checkbox"/> Absent <input type="checkbox"/> Hypersensitive | Pressure Relief <input type="checkbox"/> Dependent <input type="checkbox"/> Independent <input type="checkbox"/> Assist Method: _____ | |
| Skin Issues/Skin Integrity Current skin issues? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Intact <input type="checkbox"/> Red area <input type="checkbox"/> Open Area <input type="checkbox"/> Scar Tissue <input type="checkbox"/> At risk from prolonged sitting Where: _____ | Does beneficiary have a history of skin issues (e.g. allergies)? <input type="checkbox"/> YES <input type="checkbox"/> NO Describe: _____ _____ | Does beneficiary have a history of skin flap surgeries? <input type="checkbox"/> YES <input type="checkbox"/> NO Where: _____ When: _____ |
| Complaint of Pain: (Describe) _____ | | |

SECTION 6: ADL STATUS (in reference to wheelchair use)

| | Indep | Assist | Unable | Indep with Equip | Not assessed | Comments |
|--|-------|--------|--------|------------------|--------------|-----------------|
| Dressing | | | | | | |
| Eating | | | | | | |
| Grooming/Hygiene | | | | | | |
| Bowel Mgmt: <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent <input type="checkbox"/> Accidents | | | | | | Comments: _____ |
| Bladder Mgmt: <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent <input type="checkbox"/> Accidents | | | | | | Comments: _____ |

SECTION 7: COMMUNICATION

Does beneficiary use a speech generating device? YES NO If YES, provide Manufacturer/Model : _____
 SGD mount needed? YES NO If YES, describe: _____

SECTION 8: WHEELCHAIR (W/C) SKILLS

| | Indep | Assist | Dependent/unable | N/A | Comments (specify) |
|--|--|--------------------------|--------------------------|--------------------------|---|
| Bed ↔ Wheelchair Transfers | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| W/C ↔ Commode Transfers | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Operate Power W/C: Std. Joystick | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Safe <input type="checkbox"/> Functional Distance: _____ |
| Operate Power W/C: w/ Alternative Controls | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Safe <input type="checkbox"/> Functional Distance: _____ |
| <input type="checkbox"/> Manual W/C Propulsion <input type="checkbox"/> Power Assist Manual W/C | <input type="checkbox"/> UE or LE strength and endurance sufficient to propel 60 ft. | | | | Arm: <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both Foot: <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both |
| Operate Scooter | <input type="checkbox"/> Strength, hand grip, balance, transfer appropriate for use <input type="checkbox"/> Living environment appropriate for scooter use | | | | |
| Total hours in wheelchair per day: _____ | | | | | |

Beneficiary Name: _____

mihealth Number: _____

SECTION 9: MOBILITY/BALANCE

| Balance | | Ambulation (within 1 minute) |
|---|--|---|
| Sitting Balance | Standing Balance | |
| <input type="checkbox"/> WFL <input type="checkbox"/> Uses UE for balance in sitting <input type="checkbox"/> Min Assist <input type="checkbox"/> Mod Assist <input type="checkbox"/> Max Assist <input type="checkbox"/> Unable | <input type="checkbox"/> WFL <input type="checkbox"/> Min Assist <input type="checkbox"/> Mod Assist <input type="checkbox"/> Max Assist <input type="checkbox"/> Unable <input type="checkbox"/> Uses Assistive Device | <input type="checkbox"/> Independent > or = 150 ft. <input type="checkbox"/> Ambulates with Assist > or = 150 ft. <input type="checkbox"/> Ambulates with Device > or = 150 ft. <input type="checkbox"/> Indep. Short Distance Only < 150 ft. <input type="checkbox"/> Unable to Ambulate <input type="checkbox"/> Endurance Explain: _____ |

SECTION 10: POWER MOBILITY SAFETY

Handedness: Right Left Comments: _____

Functional Processing Skills for Wheeled Mobility
 Are beneficiary's processing skills adequate for safe wheelchair operation? YES NO
 Age appropriate? YES NO Explain: _____

Does the beneficiary demonstrate ability to operate wheelchair safely? YES NO
 Is beneficiary able to navigate within room/home? YES NO
 Is beneficiary able to navigate within facility or school? YES NO N/A

Skills for operating a power wheelchair: (Document your assessment of the beneficiary's ability to operate a power wheelchair addressing the items below.)

| | GOOD | FAIR | POOR | | GOOD | FAIR | POOR |
|-----------------------------------|--------------------------|--------------------------|--------------------------|------------------------------|--------------------------|--------------------------|--------------------------|
| Head Control/Head Position | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Visual/Spatial Perception | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Upper Extremity Functioning-Right | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Safety | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Upper Extremity Functioning-Left | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Mobility Skills in Operation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Joystick Control Steering | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cognitive Level | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Directionality-Steering Skill | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | |

SECTION 11: CURRENT MOBILITY/SEATING

Current Mobility Base: None Dependent Without Tilt With Tilt Manual Scooter Outdoor base
 Power - Type of Control: _____

Manufacturer: _____ Model: _____ Serial #: _____
 Size: _____ Base Age: _____

Current Condition of Mobility Base: _____

Current Seating System: _____ Age of Seating System: _____

| COMPONENT | MANUFACTURER/CONDITION | | |
|---------------------------------|--|--|------------------------|
| | Under Warranty | Reusable | Describe Reason Needed |
| Seat (specify) | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| Cushion (specify) | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| Back (specify) | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| Lateral trunk supports | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| Thigh support | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| Knee support | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| Foot support | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| Foot strap | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| Head support | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| Pelvic stabilization | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| Anterior Chest/Shoulder Support | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| UE Support | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| Other: (describe) | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO | |

Beneficiary Name: _____

mihealth Number: _____

Overall seat height: _____ Overall W/C length: _____ Overall W/C width: _____
(includes seat and cushion) (includes footrest)

Growth adaptability for pediatrics:

Seat width: _____ Seat depth: _____

Seating system height: _____ Frame growth adaptability: _____

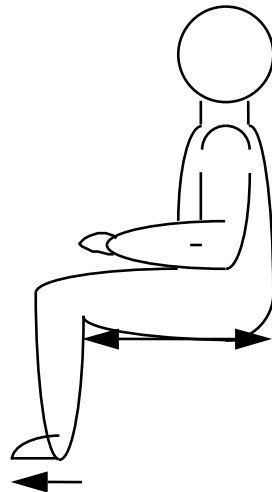
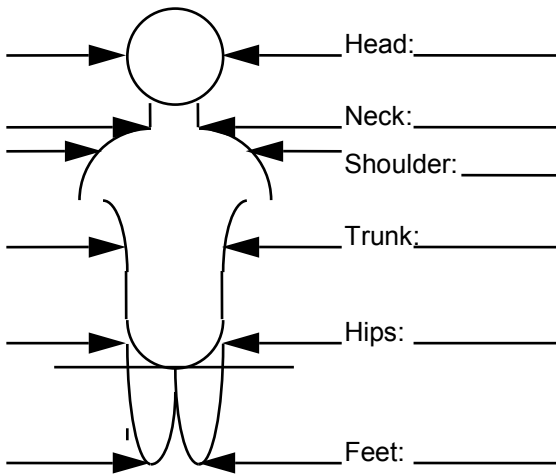
Describe posture in present seating system:

List other mobility devices (i.e., stroller, manual, power, etc.):

SECTION 12: MAT EVALUATION

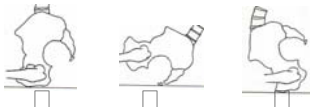
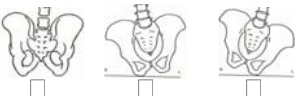


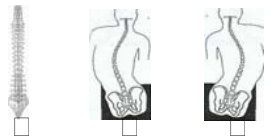

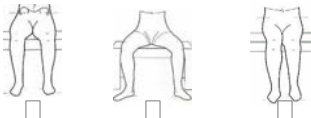

Width at the:

Height:



| | L | R |
|--------------|-------|-------|
| Crown: | _____ | _____ |
| Occiput: | _____ | _____ |
| Shoulder: | _____ | _____ |
| Axilla: | _____ | _____ |
| Elbow: | _____ | _____ |
| Seat Depth: | _____ | _____ |
| Leg Length: | _____ | _____ |
| Foot Length: | _____ | _____ |

Describe reflexes/tonal influence on body:

| POSTURE: | | | COMMENTS: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|--|--|------|-------|---------|--|-----------|--|-----------------|--|------|-------|---------|--|-----------|--|--|---------------------|--|------|-------|--------------|--|----------------|--|-----------|--|----------|--|--|
| PELVIS | Lateral View Anterior / Posterior  Neutral Posterior Anterior <input type="checkbox"/> Fixed <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Other | AP View Obliquity  WFL R elev L elev <input type="checkbox"/> Fixed <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Other | Superior View Rotation-Pelvis  WFL Right Anterior Left Anterior <input type="checkbox"/> Fixed <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Other | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | TRUNK Anterior / Posterior  WFL ↑ Thoracic Kyphosis ↑ Lumbar Lordosis <input type="checkbox"/> Fixed <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Other | Left Right  WFL Convex Left Convex Right <input type="checkbox"/> c-curve <input type="checkbox"/> s-curve <input type="checkbox"/> multiple <input type="checkbox"/> Fixed <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Other | Rotation-shoulders and upper trunk  <input type="checkbox"/> Neutral <input type="checkbox"/> Left anterior <input type="checkbox"/> Right anterior <input type="checkbox"/> Fixed <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Other | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Describe LE Neurological Influence/Tone: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| HIPS | Anterior View Position  Neutral ABduct Adduct <input type="checkbox"/> Fixed <input type="checkbox"/> Subluxed <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Dislocated <input type="checkbox"/> Flexible | Superior View Windswept  Neutral Right Left <input type="checkbox"/> Fixed <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Other | Hip Flexion/Extension Limitations: (PROM in Degrees) Hip Internal/External Range of Motion Limitations: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | KNEES & FEET Knee <table border="1" style="display: inline-table; margin-right: 20px;"> <tr> <td colspan="2">PROM Degrees</td> </tr> <tr> <td>Left</td> <td>Right</td> </tr> <tr> <td>Flexion</td> <td></td> </tr> <tr> <td>Extension</td> <td></td> </tr> </table> <table border="1" style="display: inline-table;"> <tr> <td colspan="2">Strength</td> </tr> <tr> <td>Left</td> <td>Right</td> </tr> <tr> <td>Flexion</td> <td></td> </tr> <tr> <td>Extension</td> <td></td> </tr> </table> | PROM Degrees | | Left | Right | Flexion | | Extension | | Strength | | Left | Right | Flexion | | Extension | | Foot Positioning <table border="1" style="display: inline-table;"> <tr> <td colspan="2">PROM Degrees</td> </tr> <tr> <td>Left</td> <td>Right</td> </tr> <tr> <td>Dorsi-Flexed</td> <td></td> </tr> <tr> <td>Plantar Flexed</td> <td></td> </tr> <tr> <td>Inversion</td> <td></td> </tr> <tr> <td>Eversion</td> <td></td> </tr> </table> | PROM Degrees | | Left | Right | Dorsi-Flexed | | Plantar Flexed | | Inversion | | Eversion | | |
| PROM Degrees | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Left | Right | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Flexion | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Extension | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Strength | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Left | Right | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Flexion | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Extension | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PROM Degrees | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Left | Right | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Dorsi-Flexed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Plantar Flexed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Inversion | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Eversion | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| POSTURE: | | | COMMENTS | | | | | | | | | | | | | | | | | | | | |
|---|--|---|--|-----------|-------|----------------------------------|----------------------------------|------------------------------------|---|---|---|--------|--|--|--|------|--|------|-------|----------------------------------|----------------------------------|------------------------------------|------------------------------------|
| HEAD & NECK | <input type="checkbox"/> Functional <input type="checkbox"/> Flexed <input type="checkbox"/> Extended <input type="checkbox"/> Rotated L <input type="checkbox"/> Lat Flexed L <input type="checkbox"/> Rotated R <input type="checkbox"/> Lat Flexed R <input type="checkbox"/> Cervical Hyperextension | <input type="checkbox"/> Good Head Control <input type="checkbox"/> Adequate Head Control <input type="checkbox"/> Limited Head Control <input type="checkbox"/> Absent Head Control | Describe Tone/Movement of Head and Neck: | | | | | | | | | | | | | | | | | | | | |
| | Upper Extremity <table border="1"> <tr> <th colspan="2">SHOULDERS</th> <th rowspan="2">UE Strength Concerns:</th> </tr> <tr> <th>Left</th> <th>Right</th> </tr> <tr> <td> <input type="checkbox"/> Functional $\geq 90^\circ$ <input type="checkbox"/> Flexion <input type="checkbox"/> Abduction </td> <td> <input type="checkbox"/> Functional $\geq 90^\circ$ <input type="checkbox"/> Flexion <input type="checkbox"/> Abduction </td> <td rowspan="2"> <input type="checkbox"/> N/A <input type="checkbox"/> None <input type="checkbox"/> Concerns: </td> </tr> <tr> <th colspan="2">ELBOWS</th> </tr> <tr> <td colspan="2"> <table border="1"> <tr> <th colspan="2">AROM</th> </tr> <tr> <th>Left</th> <th>Right</th> </tr> <tr> <td>Flexion <input type="checkbox"/></td> <td>Flexion <input type="checkbox"/></td> </tr> <tr> <td>Extension <input type="checkbox"/></td> <td>Extension <input type="checkbox"/></td> </tr> </table> </td> <td>Strength Concerns:</td> </tr> </table> | | | SHOULDERS | | UE Strength Concerns: | Left | Right | <input type="checkbox"/> Functional $\geq 90^\circ$ <input type="checkbox"/> Flexion <input type="checkbox"/> Abduction | <input type="checkbox"/> Functional $\geq 90^\circ$ <input type="checkbox"/> Flexion <input type="checkbox"/> Abduction | <input type="checkbox"/> N/A <input type="checkbox"/> None <input type="checkbox"/> Concerns: | ELBOWS | | <table border="1"> <tr> <th colspan="2">AROM</th> </tr> <tr> <th>Left</th> <th>Right</th> </tr> <tr> <td>Flexion <input type="checkbox"/></td> <td>Flexion <input type="checkbox"/></td> </tr> <tr> <td>Extension <input type="checkbox"/></td> <td>Extension <input type="checkbox"/></td> </tr> </table> | | AROM | | Left | Right | Flexion <input type="checkbox"/> | Flexion <input type="checkbox"/> | Extension <input type="checkbox"/> | Extension <input type="checkbox"/> |
| SHOULDERS | | UE Strength Concerns: | | | | | | | | | | | | | | | | | | | | | |
| Left | Right | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Functional $\geq 90^\circ$ <input type="checkbox"/> Flexion <input type="checkbox"/> Abduction | <input type="checkbox"/> Functional $\geq 90^\circ$ <input type="checkbox"/> Flexion <input type="checkbox"/> Abduction | <input type="checkbox"/> N/A <input type="checkbox"/> None <input type="checkbox"/> Concerns: | | | | | | | | | | | | | | | | | | | | | |
| ELBOWS | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="1"> <tr> <th colspan="2">AROM</th> </tr> <tr> <th>Left</th> <th>Right</th> </tr> <tr> <td>Flexion <input type="checkbox"/></td> <td>Flexion <input type="checkbox"/></td> </tr> <tr> <td>Extension <input type="checkbox"/></td> <td>Extension <input type="checkbox"/></td> </tr> </table> | | AROM | | Left | Right | Flexion <input type="checkbox"/> | Flexion <input type="checkbox"/> | Extension <input type="checkbox"/> | Extension <input type="checkbox"/> | Strength Concerns: | | | | | | | | | | | | | |
| AROM | | | | | | | | | | | | | | | | | | | | | | | |
| Left | Right | | | | | | | | | | | | | | | | | | | | | | |
| Flexion <input type="checkbox"/> | Flexion <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | |
| Extension <input type="checkbox"/> | Extension <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | |
| WRIST & HAND <table border="1"> <tr> <th colspan="2">Grasp</th> <th rowspan="2">Strength / Dexterity:</th> </tr> <tr> <th>Left</th> <th>Right</th> </tr> <tr> <td>Partial <input type="checkbox"/></td> <td>Partial <input type="checkbox"/></td> <td rowspan="2"></td> </tr> <tr> <td>Full <input type="checkbox"/></td> <td>Full <input type="checkbox"/></td> </tr> </table> | Grasp | | Strength / Dexterity: | Left | Right | Partial <input type="checkbox"/> | Partial <input type="checkbox"/> | | Full <input type="checkbox"/> | Full <input type="checkbox"/> | | | | | | | | | | | | | |
| Grasp | | Strength / Dexterity: | | | | | | | | | | | | | | | | | | | | | |
| Left | Right | | | | | | | | | | | | | | | | | | | | | | |
| Partial <input type="checkbox"/> | Partial <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | |
| Full <input type="checkbox"/> | Full <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | |

SECTION 13: GOALS AND EQUIPMENT TRIALS

Goals for Wheelchair Mobility (Check all that apply.)

- Independence with mobility in the home and motor related ADLs (MRADLs) in the community (independence is - no help or oversight provided, and has physically demonstrated independence in operating requested equipment)
- Provide dependent mobility
- Provide recline
- Provide tilt
- Assisted mobility
- Other: Explain: _____

Growth adaptability:

Seat width: _____ Seat depth: _____

Seating system height: _____ Frame growth adaptability: _____

Goals for Seating System (Check all that apply.)

- Optimize pressure relief
- Provide support needed to facilitate function or safety
- Provide corrective forces to assist with maintaining or improving posture
- Accommodate client's posture: (current seated postures and positions are not flexible or will not tolerate corrective forces)
- Client to be independent with relieving pressure in the wheelchair
- Enhance physiological function, such as breathing, swallowing, digestion
- Change in structure
- Other: Explain _____

Growth adaptability (Please describe) _____

Simulation ideas:

State the specific economic alternatives considered and provide model and brand:

Trial model and brand:

State why other equipment was unsuccessful:

Describe trial in prescribed wheelchair:

Does the beneficiary require the mobility item for at least ten (10) months? YES NO

SECTION 14: LICENSED MEDICAL PROFESSIONAL ATTESTATION AND SIGNATURE/DATE

I certify that I conducted the evaluation and have completed the information presented in Sections 1 - 13 and that I am not employed or have any other financial arrangement with the selected durable medical equipment provider. I certify that the information contained in this form is true, accurate, and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Licensed Medical Professional Signature: _____

Date: _____

SECTION 15: NARRATIVE DESCRIPTION OF EQUIPMENT AND COST

This section is to be completed by the DME Provider (designed to accommodate equipment from two separate providers, i.e. Provider A and Provider B) and then signed by the treating physician as directed below:

Provider A:

Provide the following information: HCPCS code and modifier; quantity; brand; model, catalog or part number; narrative description of all items, accessories and options suggested ordered; and Supplier's charge. (Attach additional sheets if needed.)

| LINE NO. | DESCRIPTION OF SERVICE (MUST INCLUDE BRAND NAME, MODEL, CATALOG OR PART NUMBER) | PROCEDURE CODE | MODIFIER | QUANTITY | CHARGE |
|----------|--|----------------|----------|----------|--------|
| 01 | | | | | |
| 02 | | | | | |
| 03 | | | | | |
| 04 | | | | | |
| 05 | | | | | |
| 06 | | | | | |
| 07 | | | | | |

Beneficiary Name: _____

mihealth Number: _____

I certify that the services and items being supplied under this request are consistent with the MSA-1656 assessment for this beneficiary and that the requested items are appropriate and can safely be used in the beneficiary's environment when used as described in the MSA-1656 assessment.

I understand that, as the Supplier, I will be reimbursed in accordance with pricing guidelines of the state Medicaid program for Durable Medical Equipment and that I will not be paid more than the amount authorized.

I will not seek any additional payment above the amount Medicaid authorized from the nursing facility, beneficiary or beneficiary's responsible party, or other party for any equipment authorized. I also agree that modifications and adjustments (for equipment authorized as a result of this assessment) required within the first six months of delivery are covered within the authorized amount.

I understand that services and items requested herein require prior approval and, if approved and submitted on the appropriate invoice, payment and satisfaction of approved services will be from federal and/or state funds. I understand that any false claims, statements or documents, or concealment of a material fact may lead to prosecution under applicable federal and/or state law.

Name of person completing information: _____ Date: _____

Name of DME Company: _____ Phone: _____

Address: _____

Provider B:

Provide the following information: HCPCS code and modifier; quantity; brand; model, catalog or part number; narrative description of all items, accessories and options suggested ordered; and Supplier's charge. (Attach additional sheets if needed.)

| LINE NO. | DESCRIPTION OF SERVICE (MUST INCLUDE BRAND NAME, MODEL, CATALOG OR PART NUMBER) | PROCEDURE CODE | MODIFIER | QUANTITY | CHARGE |
|----------|--|----------------|----------|----------|--------|
| 01 | | | | | |
| 02 | | | | | |
| 03 | | | | | |
| 04 | | | | | |
| 05 | | | | | |
| 06 | | | | | |
| 07 | | | | | |

I certify that the services and items being supplied under this request are consistent with the MSA-1656 assessment for this beneficiary and that the requested items are appropriate and can safely be used in the beneficiary's environment when used as described in the MSA-1656 assessment.

I understand that, as the Supplier, I will be reimbursed in accordance with pricing guidelines of the state Medicaid program for Durable Medical Equipment and that I will not be paid more than the amount authorized.

I will not seek any additional payment above the amount Medicaid authorized from the nursing facility, beneficiary or beneficiary's responsible party, or other party for any equipment authorized. I also agree that modifications and adjustments (for equipment authorized as a result of this assessment) required within the first six months of delivery are covered within the authorized amount.

I understand that services and items requested herein require prior approval and, if approved and submitted on the appropriate invoice, payment and satisfaction of approved services will be from federal and/or state funds. I understand that any false claims, statements or documents, or concealment of a material fact may lead to prosecution under applicable federal and/or state law.

Beneficiary Name: _____ mihealth Number: _____

Name of person completing information: _____ Date: _____

Name of DME Company: _____ Phone: _____

Address: _____

SECTION 16: MOBILITY ASSESSMENT - NURSING FACILITY

This section is to be completed by the Nursing Facility Director of Nursing, Nursing Facility Administrator or treating physician.

Date of Admission to Nursing Facility: _____

Mobility History:

- Uses Nursing Facility Per Diem Chair Uses own personal chair

Wheelchair Description:

Brand: _____ Model Number: _____

Serial number: _____

Components: _____

Customized Wheelchair Documentation (Required documentation to accompany this form)

- Most Recent MDS Past Two Months of Nursing Notes
- Current Plan of Care

R.N./Director of Nursing Signature: _____ Date: _____

Print Name: _____

Nursing Facility Administrator Signature: _____ Date: _____

Print Name: _____

Treating Physician Signature: _____ Date _____

Print Name: _____

SECTION 17: TREATING PHYSICIAN ATTESTATION AND SIGNATURE/DATE

I certify that I am the treating physician identified in the beneficiary section of this form. I have reviewed Sections 1-13 of the assessment. I have reviewed the costs and equipment recommended for this beneficiary in Sections 15. Any statement on my letterhead attached hereto and prescription have been reviewed and signed by me. I certify the information contained in this form is true, accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Treating Physician Signature: _____ Date: _____

Address: _____ Phone number: _____

_____ NPI Number: _____