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| **MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES**  **Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices**  **Addendum B: Strollers, Gait Trainers, Standers, Car Seats, and Children’s Positioning Chairs**  **This form must be completed by a physical therapist, occupational therapist, physiatrist, or rehabilitation registered nurse. The Evaluator must complete requested and/or current equipment information, warranty information and economic alternative information.**  **NOTE: Only complete sections that apply to the requested equipment/accessories. If requesting an equipment/accessories complete Current/None area of the section.**  **Incomplete information will result in the form being returned to the evaluator for completion.** |

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| Beneficiary Name: |  | Mihealth Number: |  |

| **SECTION** | | | **Requested** | | **Current  None** | | |
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| **Equipment** | | | **Beneficiary's ability to use** | |  | | |
| **Stroller** | | | Transport only  Primary mobility device  Indicate medical special needs for use and adaptions needed:       . | | Specify brand, model and serial numbers, age of current device:    Length of warranty:  Warranty begin date: | | |
| Where is or will this device be used? *(i.e., home, school, community)* | | |
|  | | | **Requested** | | | | **Current  None** |
| **Gait trainer** *(if less than age 21)* | | | Is independent with gait trainer.  Requires assistance with mobility using gait trainer.  Describe:  How many times per day will beneficiary use gait trainer: | | Specify brand, model and serial numbers, age of current device:    Length of warranty:  Warranty begin date: | | |
| How far can beneficiary ambulate with gain trainer/device?       ft.  Indicate the expected performance with the requested equipment: | | Where is or will this device be used? *(i.e., home, school, community)* | | |
|  | | | Is beneficiary/caregiver compliant with current mobility plan of care?  Yes  No  If No, explain: | | | | |
|  | | | **Requested** | | | | **Current  None** |
| **Children's positioning chairs** *(if less than age 21) e.g., feeder seat, high/low seat, activity chair, etc.* | | | Home inaccessible to mobility device.  Beneficiary is > 40 lbs. with limited head and trunk control  Beneficiary has current active seizures  Beneficiary is unable to eat or be safely fed in current mobility device  Crown to hip measurement on Mat evaluation is > 26" | | Specify brand, model and serial numbers, age of current device:    Length of warranty:  Warranty begin date: | | |
| Where is or will this device be used? *(i.e., home, school, community)* | | |
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|  | | | If beneficiary is < 40 lbs. or < 26", explain why commercially available products or other mobility devices will not meet the beneficiary's medical/functional needs: | | | | |

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| Beneficiary Name: |  | Mihealth Number: |  |

|  | | | **Requested** | | | | | | **Current  None** | | |
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| **Equipment** | | | **Beneficiary's ability to use** | | | | | **Where device is used** | | | |
| **Car seat** | | | Indicate medical special needs for use and adaptions needed: | | | | | Specify brand, model and serial numbers, age of current device:    Length of warranty:  Warranty begin date: | | | |
| Where is or will this device be used? *(i.e., home, school, community)* | | | |
|  | | | **Requested** | | | | | | | **Current  None** | |
| **Stander** *(If less than age 21)* | | | Is dependent with standing  Walks with assistive device  Walks with gait trainer  Required for post-op care | | | | | Specify brand, model and serial numbers, age of current device:    Length of warranty:  Warranty begin date: | | | |
| Specify treatment plan and state any surgical or other interventions that affect standing: | | | | | Where is or will this device be used? *(i.e., home, school, community)* | | | |
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|  | | | Indicate current standing plan of care (including how many times per day and how long): | | | | | | | | |
|  | | | Is the beneficiary/caregiver compliant with standing plan of care?  YES  NO  If NO, explain: | | | | | | | | |
| **Growth adaptability of device** | | | **Requested** | | | **Current  None** | | | | | |
| Seat width: | |  | Seat width: | | |  | | |
| Seating system height: | |  | Seating system height: | | |  | | |
| Seat depth: | |  | Seat depth: | | |  | | |
| Frame adaptablility: | |  | Frame adaptablility: | | |  | | |
| **Equipment** | | | **Device Type** *(attach additional page(s) if necessary)* | | | | | **Medical Reason** | | |
| **All Accessories / Add Ons** | | | | Head & Neck Type: | | | | |  | | |
| Arms Type: | | | | |  | | |
| Feet Type: | | | | |  | | |
| Other - Describe | | | | |  | | |
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| **Medical Reason** | | | Specify Medical Reason for brand(s) and model(s) requested for this beneficiary: | | | | | | | | |

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| Beneficiary Name: |  | Mihealth Number: |  |

**EVALUATOR (PT, OT, PHYSIATRIST OR REHAB RN) ATTESTATION AND SIGNATURE/DATE**

I certify that I conducted the evaluation and have completed the information in the appropriate Sections of the MSA-1656-Addendum B and that there is no financial arrangement with the selected durable medical equipment provider and/or the evaluating clinician. I certify that the equipment requested is the most economical alternative that meets the beneficiary's basic medical and functional needs. 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.

Evaluation Date

Evaluator Name/Title (Print)

Place of Employment and Address

     

NPI Phone Number

Evaluator Signature Date

AUTHORITY: Title XIX of the Social Security Act The Michigan Department of Health and Human Services is an equal opportunity

COMPLETION: Is voluntary, but is required if payment from applicable. employer, services and programs provider.

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person’s eligibility.