

## Nursing Facility Customized Power Wheelchair (CPWC) Authorization

Is this submission a request to transfer the authorization of a CPWC to a new facility? .....  Yes  No  
(If **Yes**, complete **only Sections A, B, F and G** and submit the form.)

**Section A. Resident-Related Identifying Information**

Resident's Name	Resident's Medicaid No.	Date of Birth	Is resident age 21 or older? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Nursing Facility			
Nursing Facility Address		City, State, ZIP Code	
Resident's Legally Authorized Representative (LAR) Name		Resident's LAR Area Code and Telephone No.	
Resident's LAR Address		City, State, ZIP Code	

**Section B. Nursing Facility Identifying Information**

Nursing Facility Name	DADS Contract No.	NPI No.
Nursing Facility Address		City, State, ZIP Code
Primary Contact Name and Position	Area Code and Telephone No.	Nursing Facility Area Code and Fax No.

**Section C. Therapist Identifying Information and CPWC Assessment**

Therapist's Name and Title	<input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Physical Therapist	
Is therapist employed by the nursing facility? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No		
Therapist's Area Code and Telephone No.	Therapist's Area Code and Fax No.	Therapist's Employer Name
Mailing Address		City, State, ZIP Code

**CPWC Assessment** (Completed by Therapist)

**I. Neurological Factors**

Indicate resident's muscle tone:.....	<input type="checkbox"/> Hypertonic	<input type="checkbox"/> Absent	<input type="checkbox"/> Fluctuating	<input type="checkbox"/> Other
Describe resident's muscle tone:				
Describe active movements affected by muscle tone:				
Describe passive movements affected by muscle tone:				

Resident Name:

Describe reflexes present:

**II. Postural Control**

Head Control.....	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> None
Trunk Control.....	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> None
Upper Extremities .....	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> None
Lower Extremities .....	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> None

**III. Medical Surgical History and Plans**

Is there a *history* of decubitus/skin breakdown? .....  Yes  No  
If Yes, explain:

Is there a *current* decubitus/skin breakdown?.....  Yes  No  
If yes, explain and include the wound stage and wound dimensions of each current site:

Describe orthopedic conditions and/or range of motion limitations requiring special consideration (i.e., contractures, degree of spinal curvature, etc.):

Describe other physical limitations or concerns (i.e., respiratory):

Describe any recent or expected changes in medical/physical/functional status:

If surgery is anticipated, indicate the procedure and expected date:

Resident Name:

#### IV. Functional Assessment

Ambulatory Status .....  Nonambulatory  With assistance  Short distance only  Community ambulatory

Indicate the resident's ambulation potential (residents who ambulate more than 10 feet independently do not qualify for a CPWC):

Expected within 1 year  Not expected  Expected in the future within \_\_\_\_\_ years

Can the resident use a modified manual wheelchair for mobility? .....  Yes  No

If Yes, justification must be provided for the requested CPWC.

Is the resident totally dependent upon a wheelchair? .....  Yes  No

If Yes, explain.

Indicate the resident's transfer capabilities:

Maximum assistance  Moderate assistance  Minimum assistance  Independent

Is the resident tube fed? .....  Yes  No

If Yes, explain.

Feeding:

Maximum assistance  Moderate assistance  Minimum assistance  Independent

Dressing:

Maximum assistance  Moderate assistance  Minimum assistance  Independent

Describe other activities performed while in the CPWC. Describe access to equipment while in the CPWC to include any equipment that may be mounted or adapted to the CPWC (i.e., augmented communication device, other):

#### V. Environmental Assessment

Is the resident's living environment accessible to the CPWC? .....  Yes  No

Are ramps available in the resident's setting? .....  Yes  No

If applicable, identify and describe the resident's current and potential for participation in an educational or vocational setting.

Resident Name:

If there is a current or potential education/vocational setting identified above, complete Items a. – e.	
a. Name of education/vocational site: _____	
b. Is the site accessible to the requested CPWC?: ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
c. Are ramps available?: ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
d. Has a therapist from the educational/vocational setting been involved in this assessment?:..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
e. Name of Therapist	Area Code and Telephone No.

Complete the remaining items for all CPWC requests.  
Describe special accommodations required to charge the energy source for the CPWC (nursing facility and/or educational/vocational setting).

Describe how the CPWC will be transported.

Describe where the CPWC will be stored (nursing facility and/or educational/vocational setting).

Describe other types of equipment that will interface with the CPWC (nursing facility and/or educational/vocational setting).

**VI. Requested Equipment**

Describe the resident's current seating system, including the age of the system.

Describe the resident's current power mobility base and the age of the base.

Resident Name:

Wheelchair Type	Manufacturer
Serial No.	Date of Purchase
Describe why the current seating system does not meet the resident's needs.	
Describe the seating system that is being requested and how it must be customized to meet the resident's specific medical needs.	
Describe the power mobility base that is being requested.	
Describe the medical necessity for the requested seating system and power mobility base.	
Describe any anticipated modifications/changes to the equipment within the next five years.	

**VII. Customized Power Wheelchair**

Describe the medical necessity for CPWC and justify any accessories such as a power tilt or recline.
Is self-propulsion possible but activity is extremely labored?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, explain.

Resident Name:

Is self-propulsion possible but contrary to the treatment regimen?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, explain.
How will the CPWC be operated (i.e., hand, chin, puff, etc.)? <b>Note:</b> <i>The resident must be able to operate the power mobility system without an attendant control.</i>
Is a stop switch requested? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, explain.
Has the resident been evaluated with the drive controls proposed in this request? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Does the resident have any conditions that will necessitate possible change in access or drive controls within the next five years? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, explain.
Is the resident physically and mentally capable of operating a CPWC safely with respect to other people in the environment? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If No, what additional training is required before the resident can become independently mobile in the CPWC?
With training, is the caregiver capable of caring for and understanding how the requested CPWC will operate? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If No, what additional training or arrangements must be made?
How will training for the power equipment be accomplished? (Include the resident, caregiver(s), educational/vocational staff and others.)

Resident Name:

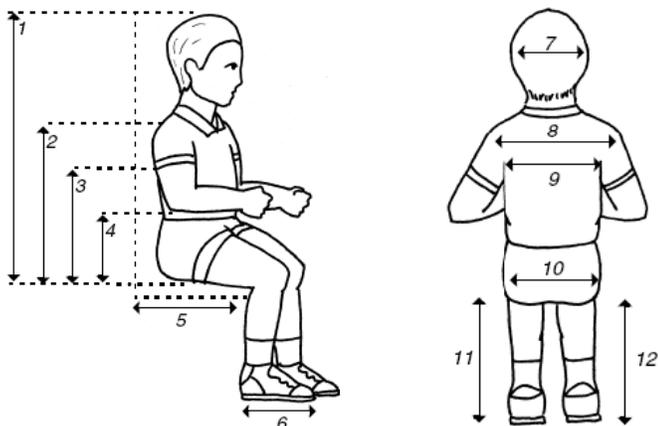
**VIII. Measuring Worksheet (Must be Completed by the Physical or Occupational Therapist)**

Resident Name				Measurement Date	
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Height	HT* Range	Weight	WT* Range	Measurements Completed by:	
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\* HT and WT Range = -/+ 20%

*(Request adult figures/diagrams)*



1. Top of head to bottom of buttocks..... \_\_\_\_\_
2. Top of shoulder to bottom of buttocks..... \_\_\_\_\_
3. Arm pit to bottom of buttocks ..... \_\_\_\_\_
4. Elbow to bottom of buttocks..... \_\_\_\_\_
5. Back of buttocks to back of knee ..... \_\_\_\_\_
6. Foot length ..... \_\_\_\_\_
7. Head width ..... \_\_\_\_\_
8. Shoulder width..... \_\_\_\_\_
9. Arm pit to arm pit..... \_\_\_\_\_
10. Hip width ..... \_\_\_\_\_
11. Distance to bottom of left leg (popliteal to heel) ..... \_\_\_\_\_
12. Distance to bottom of right leg (popliteal to heel) ..... \_\_\_\_\_

Additional Comments/Observations:

**IX. Certification by Therapist Completing CPWC Assessment (including Section VIII, Measurement Worksheet)**

Therapist's Name (Printed)	Therapist License Type and License No.
Signature – Therapist	Date

Resident Name:

**Section D. Supplier Information**

Supplier's Business Name		Area Code and Telephone No.
Supplier's Representative Completing Form		Area Code and Fax No.
Address		City, State, ZIP Code

Item No.	HCPCS Code	Description of Item	Item Price	Quantity	Total Price
1					\$
2					\$
3					\$
4					\$
5					\$
6					\$
7					\$
8					\$
9					\$
10					\$
11					\$
12					\$
13					\$
14					\$
15					\$
16					\$
17					\$
18					\$
19					\$
20					\$
21					\$
22					\$
<b>Total Amount of All Items Requested</b>					<b>\$</b>

**Supplier Certification and Acknowledgement**

1. I certify the services and items being supplied under this order are consistent with the CPWC assessment for this resident and that the requested items are appropriate and can be used safely in the resident's environment when used as described in the CPWC assessment.
2. I understand that as the supplier, I will be reimbursed in accordance with pricing guidelines of the state Medicaid program for durable medical equipment (DME) and that as the supplier, I will not be paid more than the amount authorized. **The prices listed above are MSRP and I understand that the actual authorized amount for this item is based on MSRP cost minus 18%.**
3. I acknowledge that as the supplier, I will not seek additional reimbursement than the amount authorized. I will not seek or accept any additional payment from the nursing facility, resident or resident's responsible party or other party for the CPWC. **I also acknowledge that modifications and adjustments required within the first six months of delivery of the CPWC are covered within the authorized amount.**
4. I certify the weight capacity of the requested CPWC is \_\_\_\_\_ pounds.
5. I certify that none of the items listed above are used or refurbished equipment.

Resident Name:

Name of Supplier Representative (Printed)		If Contracted Medicaid or Medicare DME Provider, enter National Provider Identifier (NPI):
Signature – Supplier Representative	Date	

**Section E. Physician-Related Information/Prescription**

**Note:** Item No. = from Section D, Supplier Information

**Diagnosis (DX) and Medical Necessity (MN) Information**

Item No.	ICD-9 Code	Brief Descriptor	MN Justification for Item
1			
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22			

Functionality/mobility status statement by physician:

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Resident Name:

**Physician's Attestation of MN for Requested CPWC** (Note: "Date Last Seen" and "Duration of Need" Items must be provided.)

Date Last Seen by Physician		Duration of Need for CPWC Month(s) or years	
By signing this form, I hereby attest that the information provided in Section E is consistent with the determination of the resident's current medical necessity and prescription. By prescribing the identified CPWC, I certify the prescribed items are appropriate and can be safely used in the resident's environment when used as prescribed.			
Signature/Attestation – Physician		Signature Date	
Physician's License No.	Physician's TPI	Physician's NPI	

**Section F. Transfer Request and Medical Professional Attestation**

I. I am formally requesting that the existing customized power wheelchair authorization for _____ be transferred from his/her previous nursing facility to the facility named in Section B of this form. He/she transferred to this facility as of _____, is currently residing in this facility and will be receiving delivery of his/her CPWC at this location.			
Name of Facility's Primary Contact (Printed)		Signature – Facility's Primary Contact	
Title of Facility's Primary Contact		Signature Date	
II. CPWC Medical Professional Certification: The medical professional certifying the statements below must be the resident's physician, an occupational therapist or a physical therapist.  I certify the following:			
<ul style="list-style-type: none"> <li>• The resident's living environment is accessible to the CPWC.</li> <li>• There are ramps available in the resident's living environment.</li> <li>• The services and items being supplied under this order are consistent with the CPWC assessment contained in the original form submitted for this resident and that the requested items are appropriate and can safely be used in the resident's environment when used as described in the CPWC assessment.</li> </ul>			
Medical Professional's Name (Printed)		Type of Medical Professional/Title	
Signature – Medical Professional		Signature Date	

**Section G: Acknowledgement and Signature of Nursing Facility Administrator for Initial Submissions and Transfer Requests**

I acknowledge that I have been made aware of the resident's DME request. I understand the appropriate facility staff or contract therapist provided the resident assessment information included in this request to support the resident's needs specific to the requested item.

Name of Nursing Facility Administrator (Printed)
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\_\_\_\_\_  
Signature – Nursing Facility Administrator

\_\_\_\_\_  
Date