



COMMISSIONER
Jon Weizenbaum

Fax Cover Sheet

Specialized Services Customized Manual Wheelchair (CMWC) Authorization Request

Date: _____

To: DADS Access and Intake PASRR Unit, Attention: Program Specialist

Area Code and Fax No.: 512-438-2180

No. of Pages including cover: _____

Additional questions, email PASRR@dads.state.tx.us

CMWC (Customized Manual Wheelchair)

From: _____

Name of Nursing Facility Representative: _____

Title of Nursing Facility Representative: _____

Area Code and Fax No.: _____

Area Code and Telephone No.: _____

Notes/Additional Comments:

Confidential Information: This communication (including any attached documentation) contains privileged and/or confidential information. If you are not an intended recipient of this communication, please be advised that any disclosure, dissemination, distribution, copying or other use of this communication or any attached document is strictly prohibited. If you have received this communication in error, please notify the sender immediately and promptly destroy all copies of this communication and any attached documentation.

Specialized Services Customized Manual Wheelchair (CMWC) Authorization Request

Is this submission a request to transfer the authorization of a CMWC to a new facility? Yes No

(If Yes, complete only Sections A, E and F and submit the form.)

- Notes:**
- This form will not be accepted if not complete, including any required additional information.
 - This form is to be used only when requesting prior authorization for a CMWC for Medicaid-eligible nursing facility residents.
 - Only nursing facility residents who are Preadmission Screening and Resident Review-eligible for Specialized Services are eligible for this benefit.
 - When completed, fax Form 1018 and the MSRP lists to: DADS Access and Intake Division, PASRR Unit, 512-438-2180.

Section A. Resident and Nursing Facility Identifying Information

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

Section B. Therapist Identifying Information and CMWC Assessment

Therapist 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 Area Code and Telephone No.	Therapist Area Code and Fax No.	Therapist Employer Name	
Mailing Address		City, State, ZIP Code	

CMWC 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
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Resident Name:

a. Describe resident's muscle tone:
b. Describe active movements affected by muscle tone:
c. Describe passive movements affected by muscle tone:
d. 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

a. Is there a <i>history</i> of decubitus/skin breakdown?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, explain:		
b. Is there a <i>current</i> decubitus/skin breakdown?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, explain and include the wound stage and wound dimensions of each current site:		

Resident Name:

c. Describe orthopedic conditions and/or range of motion limitations requiring special consideration (i.e., contractures, degree of spinal curvature, etc.):
d. Describe other physical limitations or concerns (i.e., respiratory):
e. Describe any recent or expected changes in medical/physical/functional status:
f. If surgery is anticipated, indicate the procedure and expected date:

IV. Functional Assessment

a. Ambulatory Status <input type="checkbox"/> Nonambulatory <input type="checkbox"/> With assistance <input type="checkbox"/> Short distance only <input type="checkbox"/> Community ambulatory Indicate the resident's ambulation potential (residents who ambulate more than 10 feet independently do not qualify for a CMWC): <input type="checkbox"/> Expected within 1 year <input type="checkbox"/> Not expected <input type="checkbox"/> Expected in the future within _____ years
b. Is the resident totally dependent upon a wheelchair? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, explain.
c. Is the resident tube fed? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, explain.
d. Feeding: <input type="checkbox"/> Maximum assistance <input type="checkbox"/> Moderate assistance <input type="checkbox"/> Minimum assistance <input type="checkbox"/> Independent Dressing: <input type="checkbox"/> Maximum assistance <input type="checkbox"/> Moderate assistance <input type="checkbox"/> Minimum assistance <input type="checkbox"/> Independent

Resident Name:

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

V. Environmental Assessment

a. Is the resident's living environment accessible to the CMWC?..... Yes No
 Are ramps available in the resident's setting? Yes No
 Describe how the CMWC will be transported.

b. If there is a current or potential education/vocational setting identified above, complete Items 1 – 5.

1. Name of education/vocational site: _____

2. Is the site accessible to the requested CMWC? Yes No

3. Are ramps available?..... Yes No

4. Has a therapist from the educational/vocational setting been involved in this assessment?..... Yes No

5.

Name of Therapist	Area Code and Telephone No.
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VI. Requested Equipment

a. Describe the resident's current seating system, including the mobility base and age of the system/base.

b. Wheelchair Type	c. Manufacturer
d. Serial No.	e. Date of Purchase

f. Describe why the current seating system does not meet the resident's needs.

g. Describe the seating system that is being requested and how it must be customized to meet the resident's specific medical needs.

Resident Name:

h. Describe the mobility base that is being requested.

i. Describe the medical necessity for the requested customized seating system.

j. Describe any anticipated modifications/changes to the equipment within the next five years.

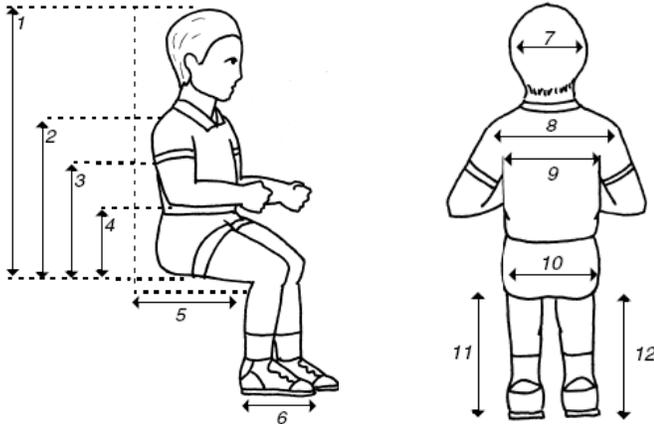
VII. Measuring Worksheet (Must be Completed by the Physical or Occupational Therapist)

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 = $\pm 20\%$

(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:

Resident Name:

VIII. Certification by Therapist Completing CMWC Assessment (including Section VII, Measurement Worksheet)	
Therapist Name (Printed)	Therapist License Type and License No.

Signature – Therapist

Date

Section C. Supplier Information and CMWC Itemized Manufacturer’s Suggested Retail Price (MSRP) Quote

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					\$
Total Amount of All Items Requested					\$

*Item price must be based on MSRP.

Resident Name:

Physician's Attestation of MN for Requested CMWC (Note: "Date last seen" and "Duration of Need" Items must be provided.)

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

Signature/Attestation – Physician

Signature Date

Section E. Transfer Request and Medical Professional Attestation

I. I am formally requesting that the existing customized manual wheelchair authorization for _____ be transferred from his/her previous nursing facility to the facility named in Section A 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 CMWC at this location.

Name of Facility's Primary Contact (Printed)	Title of Facility's Primary Contact
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Signature – Facility's Primary Contact

Signature Date

II. CMWC 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:

- The resident's living environment is accessible to the CMWC.
- There are ramps available in the resident's living environment.
- The services and items being supplied under this request are consistent with the CMWC 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 CMWC assessment.

Medical Professional's Name (Printed)	Type of Medical Professional/Title
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Signature–Medical Professional

Signature Date

Section F. 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 appropriate facility staff or contract therapist provided the resident assessment information included in this request to support the resident's needs specific to the item requested.

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

Date