Wheeled Mobility Letter of Medical Necessity Form

*INDIVIDUAL'S NAME:		*ID NUMBER:	

MEMBER INFORMATION AND BACKGROUND						
*1.	Date of Birth (mm/dd/yyyy)					
2.	Date(s) of Evaluation (mm/dd/yyyy)					
*3.	Address Line 1					
	Address Line 2					
	City		State		Zip Code	

*4.	Facility Name, if applicable Evaluation Location Address L1					
	Evaluation Location Address L 2					
	Evaluation City		Evaluation State		Evaluation Zip Code	

*5.	Height		FT		IN	Weight		LBS

*6.	INDIVIDUALS PRESENT DURING EVALUATION		
	NAME	CREDENTIALS	AGENCY or RELATIONSHIP
OCCUPATIONAL/PHYSICAL THERAPIST(s)			
DME PROVIDER/ATP			
PHYSICIAN(s), if present			
OTHER(s)			

7.	a. Primary Reason for Evaluation		b. Primary Issues Relating to DME	☐ Size ☐ Does not address current medical needs ☐ Does not address current functional needs

	DIAGNOSIS(es), RECENT SURGERIES and PROCEDURES	RELEVANT DATE(s)/DATES of ONSET or INDICATE N/A
8.		
8a.	Explain recent change in medical condition or other relevant information including symptoms, treatments and medications:	

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9. Caretaker Support: ☐ **The individual has 24 Hour Care.**

9a.	Caretaker Support Hours per Day:		Relationship/Role:	
9b.	Amount of Time Alone per Day:			

10. List all current/previous Durable Medical Equipment (DME) within past 10 years:

10a. WHEELED MOBILITY DEVICE including MANUFACTURER AND MODEL	Approximate DATE of PURCHASE	ENVIRONMENTS USED Indicate All That Apply	Is DME currently used?	Skill Level	If ineffective, provide reason
e.g. Convaid Cruiser		☐ Home		☐ Independent	
		☐ Work		☐ WNL endurance/distance	
		☐ School		☐ Below normal endurance/distance	
		☐ Community		☐ Dependent	
		☐ SNF/ICF		☐ Other:	
Comments, including special features, specialty seating components, electronics:					
Ownership	☐ Personally Owned	☐ Facility Owned	☐ Rental, include dates:	☐ Other:	

10b. WHEELED MOBILITY DEVICE including MANUFACTURER AND MODEL	Approximate DATE of PURCHASE	ENVIRONMENTS USED Indicate All That Apply	Is DME currently used?	Skill Level	If ineffective, provide reason
e.g. Convaid Cruiser		☐ Home		☐ Independent	
		☐ Work		☐ WNL endurance/distance	
		☐ School		☐ Below normal endurance/distance	
		☐ Community		☐ Dependent	
		☐ SNF/ICF		☐ Other:	
Comments, including special features, specialty seating components, electronics:					
Ownership	☐ Personally Owned	☐ Facility Owned	☐ Rental, include dates:	☐ Other:	

10c. OTHER DME TYPE including MANUFACTURER AND MODEL	Approximate DATE of PURCHASE	ENVIRONMENTS USED Indicate All That Apply		Skill Level using DME	Is DME currently used?	If ineffective, provide reason
☐ **Hygiene**		☐ Home	☐ SNF/ICF	☐ Independent	☐ Yes	
e.g. Altimate EasyStand Evolv		☐ School	☐ Community	☐ Requires Assistance	☐ No	
		☐ Work	☐ Other:	☐ Dependent	☐ N/A	
☐ **Stander**		☐ Home	☐ SNF/ICF	☐ Independent	☐ Yes	
e.g. Anthros Shower/Commode Chair		☐ School	☐ Community	☐ Requires Assistance	☐ No	
		☐ Work	☐ Other:	☐ Dependent	☐ N/A	
☐ **Other Equipment**		☐ Home	☐ SNF/ICF	☐ Independent	☐ Yes	
e.g. Hospital Bed, Patient Lift, Walker		☐ School	☐ Community	☐ Requires Assistance	☐ No	
		☐ Work	☐ Other:	☐ Dependent	☐ N/A	
☐ **Other Equipment**		☐ Home	☐ SNF/ICF	☐ Independent	☐ Yes	
		☐ School	☐ Community	☐ Requires Assistance	☐ No	
		☐ Work	Other:	☐ Dependent	☐ N/A	

*INDIVIDUAL'S NAME:		*ID NUMBER:	

11. **Functional Skills**

ACTIVITY	LEVEL OF INDEPENDENCE	COMMMENTS and EQUIPMENT USED
Bathing		
Dressing		
Grooming		
Eating		
Toileting		

12. **Orthosis(es)/Prosthesis(es)** ☐ **NA / None**

ITEM	LEFT	RIGHT	BOTH	COMMENTS/ IF INEFFECTIVE, PLEASE EXPLAIN
Ankle Foot Orthosis(es)	☐	☐	☐	
Knee-Ankle-Foot Orthosis(es)	☐	☐	☐	
Below Knee Prosthesis(es)	☐	☐	☐	
Above Knee Prosthesis(es)	☐	☐	☐	
TLSO/ LSO	N/A			
Other:	☐	☐	☐	

13. **Transfer Skills** ☐ **Independent for all transfers** ☐ **Varied transfer skills; see completed table**
☐ **Dependent for all transfers; describe transfer method and equipment used**

FROM	TO	METHOD	LEVEL OF INDEPENDENCE	EQUIPMENT

*INDIVIDUAL'S NAME:		*ID NUMBER:	

14. **Ambulation Independence:** ☐ Independent ☐ Requires assistance with ambulation ☐ Non-ambulatory ☐ Varied ambulation skills; see completed table

	LEVEL OF ASSISTANCE	SPEED	DISTANCE	ENDURANCE	SPECIFY AMBULATION AIDE	
Carpet					☐	None
Smooth					☐	None
Uneven Terrain (outside)					☐	None

15. **Coordination, Motor Control, and Balance**

ACTIVITY	UNSUPPORTED MOTOR CONTROL						COMMENTS / OTHER
Sitting Balance (Static)	☐	Steady, safe	☐	Leans or slides	☐	Unable	
Upper Extremity Gross Motor Control	☐	Functional	☐	Mild/Moderate Impairment	☐	Dependent	
Upper Extremity Fine Motor Control	☐	Functional	☐	Mild/Moderate Impairment	☐	Dependent	

16. **Range of Motion (Attach data as appropriate)**

AREA AFFECTED	RANGE OF MOTION LIMITATIONS RELATIVE TO SEATING
Right Upper Extremity	
Left Upper Extremity	
Right Lower Extremity	
Left Lower Extremity	
Head/Neck	

*INDIVIDUAL'S NAME:		*ID NUMBER:	

17. Motor Control, Muscle Strength, and Tone

	STRENGTH	(+) / (-)	TONE	COMMENTS / OTHER
Head/Neck				
Trunk				
Right Upper Extremity				
Left Upper Extremity				
Right Lower Extremity				
Left Lower Extremity				

18. Unsupported Postural Alignment: Add COMMENT regarding any abnormal finding, including quantitative data; e.g., mixed asymmetry, mixed rotation, severe misalignment between neck and trunk.

	POSTURAL ALIGNMENT	FIXED VS. FLEXIBLE	COMMENTS
Head/ Neck			
Trunk/ Spine			
Pelvis/ Hips			
Leg Length			
Ankles/ Feet/ Toes			

Other Pertinent Information:

*INDIVIDUAL'S NAME:		*ID NUMBER:	

19. Pain

☐ No Pain ☐ Unable to determine if individual is experiencing pain

LOCATION	INTENSITY	FREQUENCY	COMMENTS/QUALIFYING INFORMATION; RELATIONSHIP TO POSITIONING & MOBILITY

20. Skin integrity and Pressure Management (Optional: Attach Braden Scale www.bradenscale.com/images/bradenscale.pdf)

RISK FACTORS	☐ None	☐ Bony Prominences	☐ Aged Skin	☐ Fecal and/or Urinary Incontinence
	☐ Circulatory Compromise	☐ Impaired Nutritional Status	☐ Immobility	☐ Sensory Deficits
INDICATE HIGH RISK LOCATIONS				
CURRENT SKIN INTEGRITY STATUS	☐ Intact	☐ Impaired, indicate approximate duration:		
		Stage:	Location:	If unstageable, describe:
HISTORY of SKIN INTEGRITY	☐ Intact	☐ Impaired, indicate approximate duration:		
		Stage:	Location:	If unstageable, describe:
PRESSURE REDUCING ABILIITES		☐ Functional Self-positioning	☐Impaired Self-positioning	☐Non Self-positioning
PRESSURE REDUCING METHODS USED				

21. Cardiovascular, Pulmonary, Vascular, Bowel, and Bladder Status

	CONDITION		CLINICAL OBSERVATIONS / REFERENCE TO DIAGNOSIS
Cardiac Status			
Pulmonary Status			
Vascular Status			
If Impaired, Indicate Edema Grade Level			
Bladder Status	☐ Continent	☐ Incontinent	☐ Catheterization
Bowel Status	☐ Continent	☐ Incontinent	☐ Suppository use

*INDIVIDUAL'S NAME:		*ID NUMBER:	

22. Summarize the conditions that impact individual's ability to ambulate and/or transfer safely, independently, and in a timely manner; e.g., weakness, cardiovascular/respiratory compromise, ROM deficits, imbalance, tone, cognitive deficits, coordination, sensory deficits:

23. What other least restrictive mobility devices were considered, evaluated, or ruled out?

		Reason:
☐	Cane	
☐	Walker	
☐	Standard manual wheelchair	
☐	Lightweight wheelchair	
☐	Optimally configured ultralightweight wheelchair	
☐	Medical stroller	
☐	Power assist system	
☐	Medical scooter	
☐	Other:	

24. List the primary medical and functional objectives for the recommended wheeled mobility device, including how this will impact the individual's ADL independence:

*INDIVIDUAL'S NAME:		*ID NUMBER:	

PERSON'S ABILITY TO UTILIZE REQUESTED WHEELED MOBILITY DEVICE

25. Will this individual be able to participate in mobilizing the recommended wheeled mobility device?

☐ **If YES, complete #25** ☐ **If NO, proceed to #26**

If the individual will be mobilizing the wheeled mobility device, describe the evaluation trials and results including individual's ability to safely and independently mobilize and utilize the features of the recommended wheeled mobility device system within their customary and relevant environment(s), i.e., bedroom, bathroom, ramp, varied terrain:

Duration and frequency of evaluation trial(s):
Cognitive/ Safety/ Visual-Motor skills:
Fine/Gross Motor skills:
Strength; Endurance:
Ability to control all special features; i.e., power tilt, power recline, power leg rests, seat elevator, power assist, one arm drive, alternative mobility controls:

26. Are there anticipated changes in the individual's customary environments with the next 1-2 years? ☐ **NO** ☐ **YES**

If "yes," how was this taken into consideration for the requested wheeled mobility device?

27. For residents of Skilled Nursing Facilities:

If this request is for a replacement wheeled mobility device originally purchased under Sec. 17-134d-46 of the Regulations of Connecticut State Agencies (Customized Wheelchairs in Nursing Facilities), attach a copy of the existing 24-hour positioning plan.

What is the estimated length of time per day that the requested wheeled mobility device will be used?

28. Upon delivery, will ongoing training be necessary? ☐ **NO** ☐ **If YES, please explain:**

29. Comments (include e. g., Continued from #xx): Attach additional comments as necessary.

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Based on the clinical assessment, the following wheeled mobility device is suggested to address this individual's medical needs:

30.	* Description of DME component: This list can be pre-populated by the DME provider. Postural components can be combined with hardware; e.g., lateral trunk pads with swing-away mounting hardware; phenolic upper extremity support with channel locks and strap.	**31. Medical Rationale to be completed by evaluating therapist only: Pre-populated, generic, and general rationales and definitions will not be accepted. Information must include:** ▪ The rationale for the requested base or component for this specific individual, as correlated with the documented clinical information. ▪ If appropriate, include reason why a standard component would not address the individual's medical needs. ▪ **Rationales written by the DME provider should be designated with an asterisk** [*]. Include the reason for hardware and electronic components, as compared to less complex alternatives and correlated with necessary functional or technical outcomes.
a.		
b.		
c.		
d.		

*INDIVIDUAL'S NAME:		*ID NUMBER:
e.		
f.		
g.		
h.		
i.		
j.		
k.		
l.		

*INDIVIDUAL'S NAME:		*ID NUMBER:	

m.		
n.		
o.		
p.		
q.		
r.		
s.		
t.		
u.		

*INDIVIDUAL'S NAME:		*ID NUMBER:	

32a. I certify that I am the Licensed Occupational and/or Physical Therapist identified below. I have included my credentials, affiliated agency, address, and preferred contact information. My signature affirms that I solely wrote each section of this report, except where an asterisk [*] is designated, based upon my own clinical knowledge, training, and evaluation of the individual's medical condition.
Note: All email correspondences utilize the CHNCT secure email system.

Name:		Credentials:		CT License #:	
Agency:					
Address L1:					
Address L2:					
City:		State:		Zip Code:	
Preferred Phone Number:		Fax Number:		Preferred Email Address:	

ATTENTION: TO FACILITATE A MEDICAL NECESSITY DETERMINATION, PLEASE INDICATE THE PREFERRED METHOD FOR A MEDICAL REVIEWER TO CONTACT YOU, AS NEEDED.

☐ **PHONE** ☐ **EMAIL** ☐ **OTHER**

32b. Electronic Signature Agreement. By clicking "I agree" and electronically signing below, you certify that: (1) you and the agency/facility in which you are employed agree to follow and are in compliance with the Connecticut Department of Social Services *Conditions for DSS Acceptance of Electronic Signatures ("Electronic Signature Policy")* and (2) your electronic signature below complies with the Electronic Signature Policy. **If your agency does not comply with this Agreement, a handwritten signature is required.**

☐	**Therapist's Signature**		**Date of report (mm/dd/yyyy)**	

***33. Evaluating Assistive Technology Professional (ATP) signature is required when the ATP provides any technical documentation in #31.**

☐	**ATP's Signature and Credentials**		**Date (mm/dd/yyyy)**	

34a. Physician's Contact Information and Signature: By signing below, I have reviewed and concur with the above evaluation:

a.	**Prescribing Physician**		b.	**Physician NPI**	
c.	**Agency**		d.	**Preferred Phone Number**	
e.	**Address**				
	City		**State**	**Zip code**	
	Preferred Email		**Fax**		

34b. Electronic Signature Agreement. By clicking "I agree" and electronically signing below, you certify that: (1) you and the agency/facility in which you are employed agree to follow and are in compliance with the Connecticut Department of Social Services *Conditions for DSS Acceptance of Electronic Signatures ("Electronic Signature Policy")* and (2) your electronic signature below complies with the Electronic Signature Policy. **If your agency does not comply with this Agreement, a handwritten signature is required.**

☐	**Physician's Signature**		**Date (mm/dd/yyyy)**	

All sections on this form **must** be completed solely by the **evaluating occupational and/or physical therapist**.
Exception: Technical rationales may be completed by the evaluating ATP designated with an asterisk [*].