MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

Mobility and Seating Evaluation and Justification

Sections 1-14 must be completed by a licensed/certified 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: ☐ M ☐ F

mihealth #: _____

Treating Physician: _____

Physician Specialty: _____

Other Insurance: _____

_____

SECTION 1: BENEFICIARY ADDITIONAL INFORMATION

Beneficiary resides in Nursing Facility? ☐ YES ☐ NO

Beneficiary address: _____

_____

Beneficiary phone: _____

Designated contact person: *(i.e., parent, legal guardian, legal representative or beneficiary)*

_____

Contact person phone: _____

Evaluation date: _____ Time: _____

Evaluator name: _____

Title: _____

Date: _____ Phone: _____

Place of Employment:

_____

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: ☐ YES ☐ NO

Relevant past and future surgeries: _____

_____

Other Service - Hospice: ☐ YES ☐ NO

Height: _____ Weight: _____

Explain recent changes or trends in weight: _____

Cardio Status: (Check) Functional Limitations:

☐ Intact ☐ Impaired ☐ N/A

Respiratory Status: (Check) Functional Limitations:

☐ Intact ☐ Impaired ☐ N/A

Orthotics (describe):

SECTION 3: HOME ENVIRONMENT

Does beneficiary reside in: ☐ House ☐ Condo/town home ☐ Apartment ☐ Assisted Living ☐ Nursing Facility ☐ Adult Foster Care (AFC) ☐ Group Home

Does beneficiary live alone? ☐ YES ☐ NO

Does beneficiary have a caregiver? ☐ YES ☐ NO If YES, how many hours with caregiver? _____

Is the home wheelchair accessible for the beneficiary? ☐ YES ☐ NO

Storage of Wheelchair: ☐ In home ☐ School ☐ Other

Comments: _____

*A licensed/certified 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. (PTA, COTA, OTA may not evaluate for or 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 tiedowns 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 ☐ Intact ☐ Impaired ☐ Absent ☐ Hypersensitive	**Pressure Relief** ☐ Dependent ☐ Independent ☐ Assist Method:	
Skin Issues/Skin Integrity Current skin issues? ☐ YES ☐ NO ☐ Intact ☐ Red area ☐ Open Area ☐ Scar Tissue ☐ At risk from prolonged sitting Where:	Does beneficiary have a history of skin issues (e.g. allergies)? ☐ YES ☐ NO Describe: _____	Does beneficiary have a history of skin flap surgeries? ☐ YES ☐ 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: ☐ Continent ☐ Incontinent ☐ Accidents						Comments:
Bladder Mgmt: ☐ Continent ☐ Incontinent ☐ 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	☐	☐	☐	☐	
W/C ↔ Commode Transfers	☐	☐	☐	☐	
Operate Power W/C: Std. Joystick	☐	☐	☐	☐	☐ Safe ☐ Functional Distance:
Operate Power W/C: w/ Alternative Controls	☐	☐	☐	☐	☐ Safe ☐ Functional Distance:
☐ Manual W/C Propulsion ☐ Power Assist Manual W/C	☐ UE or LE strength and endurance sufficient to propel 60 ft.				Arm: ☐ left ☐ right ☐ both Foot: ☐ left ☐ right ☐ both
	Comments:				
Operate Scooter	☐ Strength, hand grip, balance, transfer appropriate for use ☐ Living environment appropriate for scooter use				
Total hours in wheelchair per day:					

Beneficiary Name: _____ **mihealth** Number: _____

SECTION 9: MOBILITY/BALANCE

Balance		Ambulation
Sitting Balance	Standing Balance	
☐ WFL ☐ Uses UE for balance in sitting ☐ Min Assist ☐ Mod Assist ☐ Max Assist ☐ Unable	☐ WFL ☐ Min Assist ☐ Mod Assist ☐ Max Assist ☐ Unable ☐ Uses Assistive Device	☐ Independent > or = 150 ft. ☐ Ambulates with Assist > or = 150 ft. ☐ Ambulates with Device > or = 150 ft. ☐ Indep. Short Distance Only < 150 ft. ☐ Unable to Ambulate ☐ 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
Head Control/Head Position	☐	☐	☐
Upper Extremity Functioning-Right	☐	☐	☐
Upper Extremity Functioning-Left	☐	☐	☐
Joystick Control Steering	☐	☐	☐
Directionality-Steering Skill	☐	☐	☐

	GOOD	FAIR	POOR
Visual/Spatial Perception	☐	☐	☐
Safety	☐	☐	☐
Mobility Skills in Operation	☐	☐	☐
Cognitive Level	☐	☐	☐

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: _____

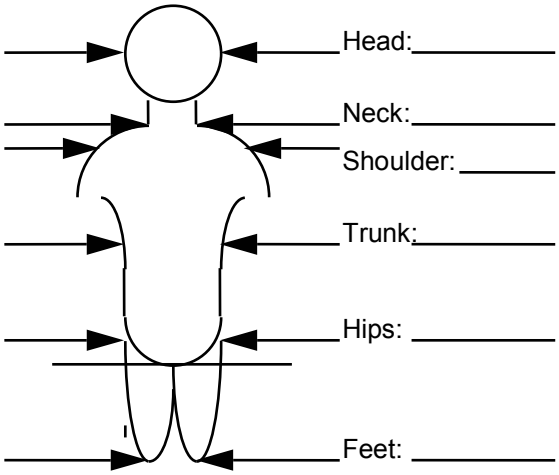
COMPONENT	MANUFACTURER/CONDITION		
	Under Warranty	Reusable	Describe Reason Needed
Seat (specify)	☐ YES ☐ NO	☐ YES ☐ NO	
Cushion (specify)	☐ YES ☐ NO	☐ YES ☐ NO	
Back (specify)	☐ YES ☐ NO	☐ YES ☐ NO	
Lateral trunk supports	☐ YES ☐ NO	☐ YES ☐ NO	
Thigh support	☐ YES ☐ NO	☐ YES ☐ NO	
Knee support	☐ YES ☐ NO	☐ YES ☐ NO	
Foot support	☐ YES ☐ NO	☐ YES ☐ NO	
Foot strap	☐ YES ☐ NO	☐ YES ☐ NO	
Head support	☐ YES ☐ NO	☐ YES ☐ NO	
Pelvic stabilization	☐ YES ☐ NO	☐ YES ☐ NO	
Anterior Chest/Shoulder Support	☐ YES ☐ NO	☐ YES ☐ NO	
UE Support	☐ YES ☐ NO	☐ YES ☐ NO	
Other: (describe)	☐ YES ☐ NO	☐ YES ☐ NO	

Beneficiary Name: _____ **mihealth** Number: _____

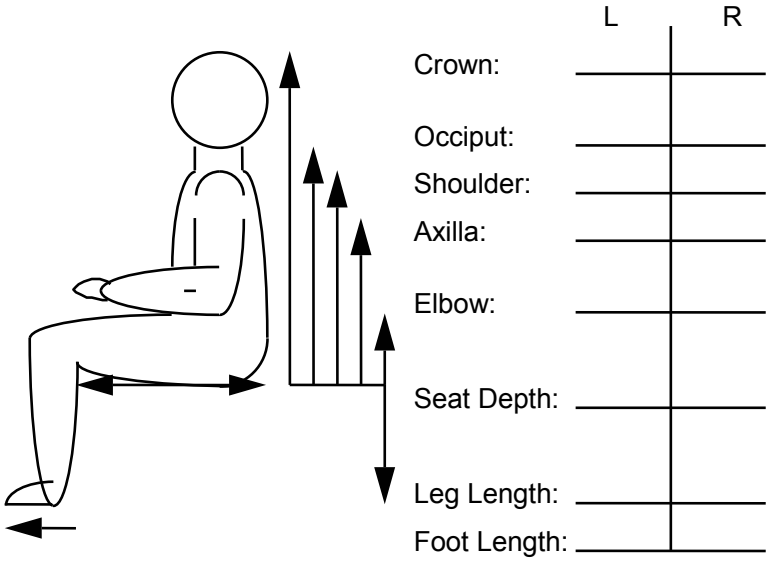
Overall seat height: _____ (includes seat and cushion)	Overall W/C length: _____ (includes footrest)	Overall W/C width: _____
Growth adaptability for pediatrics: Seat width: _____ Seating system height: _____		Seat depth: _____ Frame growth adaptability: _____
Describe posture in present seating system:		
List other mobility devices (i.e., stroller, manual, power, etc.):		

SECTION 12: MAT EVALUATION

Width at the:

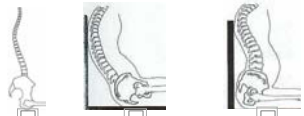
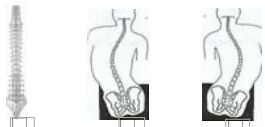
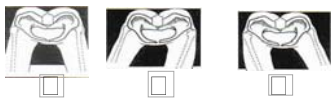


Height:



Describe reflexes/tonal influence on body:

Beneficiary Name: _____ **mihealth** Number:_____

POSTURE:				COMMENTS:
	Lateral View	**AP View**	**Superior View**	
PELVIS	**Anterior / Posterior**  ☐ Neutral ☐ Posterior ☐ Anterior ☐ Fixed ☐ Flexible ☐ Partly Flexible ☐ Other	**Obliquity**  ☐ WFL ☐ R elev ☐ L elev ☐ Fixed ☐ Flexible ☐ Partly Flexible ☐ Other	**Rotation-Pelvis**  ☐ WFL ☐ Right Anterior ☐ Left Anterior ☐ Fixed ☐ Flexible ☐ Partly Flexible ☐ Other	
TRUNK	**Anterior / Posterior**  ☐ WFL ☐ ↑ Thoracic Kyphosis ☐ ↑ Lumbar Lordosis ☐ Fixed ☐ Flexible ☐ Partly Flexible ☐ Other	**Left Right**  ☐ WFL ☐ Convex Left ☐ Convex Right ☐ c-curve ☐ s-curve ☐ multiple ☐ Fixed ☐ Flexible ☐ Partly Flexible ☐ Other	**Rotation-shoulders and upper trunk**  ☐ Neutral ☐ Left anterior ☐ Right anterior ☐ Fixed ☐ Flexible ☐ Partly Flexible ☐ Other	
	Describe LE Neurological Influence/Tone:			
	Anterior View	**Superior View**		**COMMENTS:**
HIPS	**Position**  ☐ Neutral ☐ ABduct ☐ Adduct ☐ Fixed ☐ Subluxed ☐ Partly Flexible ☐ Dislocated ☐ Flexible	**Windswept**  ☐ Neutral ☐ Right ☐ Left ☐ Fixed ☐ Flexible ☐ Partly Flexible ☐ Other	**Hip Flexion/Extension Limitations: (PROM in Degrees)** **Hip Internal/External Range of Motion Limitations:**	

KNEES & FEET

Knee

PROM Degrees	Left	Right
Flexion		
Extension		

Strength	Left	Right
Flexion		
Extension		

Foot Positioning

PROM Degrees	Left	Right
Dorsi-Flexed		
Plantar Flexed		
Inversion		
Eversion		

Beneficiary Name: _____ **mihealth** Number: _____

POSTURE:				COMMENTS
HEAD & NECK	☐ Functional ☐ Flexed ☐ Extended ☐ Rotated L ☐ Lat Flexed L ☐ Rotated R ☐ Lat Flexed R ☐ Cervical Hyperextension	☐ Good Head Control ☐ Adequate Head Control ☐ Limited Head Control ☐ Absent Head Control	**Describe Tone/Movement of Head and Neck:**	
Upper Extremity	**SHOULDERS** **Left** ☐ Functional ≥ 90° ☐ Flexion ☐ Abduction **Right** ☐ Functional ≥ 90° ☐ Flexion ☐ Abduction	**UE Strength Concerns:** ☐ N/A ☐ None ☐ Concerns:	**Describe Tone/Movement of UE:**	
	ELBOWS **AROM** Left / Right Flexion ☐ ☐ Extension ☐ ☐	**Strength Concerns:**		
WRIST & HAND	**Grasp** Left / Right Partial ☐ ☐ Full ☐ ☐	**Strength / Dexterity:**		

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/CERTIFIED 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 knowlege, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Licensed/Certified 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: _____