

## CSHCN Services Program Wheelchair Seating Evaluation Form and Instructions

### General Information

- Ensure the most recent version of the Wheelchair Seating Evaluation form is submitted. The form is available on the TMHP website at [www.tmhp.com](http://www.tmhp.com).
- **Complete all sections of this form.**
- Print or type all information.
- Contact the TMHP-CSHCN Services Program Contact Center at 1-512-514-3000, option 2, or 1-800-568-2413, Monday through Friday, from 7 a.m. to 7 p.m., Central Time, for assistance with this form.
- This form may be submitted by mail to the following address:  

TMHP-CSHCN Services Program Authorization Department  
 12357-B Riata Trace Parkway Ste #150 MC-A11  
 Austin, TX 78727
- This form may be submitted by fax to 1-512-514-4222.
- Submit only the evaluation form. Do not submit instruction pages.
- Refer to: Chapter 17, "Durable Medical Equipment (DME)."

### Client Information

Field Description	Guidelines
First name	Enter the client's first name as indicated on the CSHCN Services Program eligibility form
Last name	Enter the client's last name as indicated on the CSHCN Services Program eligibility form
CSHCN Services Program number	Enter the client's ID number as indicated on the CSHCN Services Program eligibility form
Date of birth	Enter the client's date of birth as indicated on the CSHCN Services Program eligibility form
Client's Height	Enter the client's height
Clients Weight	Enter the client's weight
Address/City/State/ZIP	Enter the client's address, city, state, and ZIP
Diagnosis (ICD-9-CM)	Enter the diagnosis code relevant to the client's condition

### Part I – Neurological Factors (Required for manual and power wheelchairs)

Field Description	Guidelines
Client's muscle tone	Indicate client's muscle tone (hypertonic, absent, fluctuating, other)
If other, describe client's muscle tone	If the client's muscle tone is not indicated in previous field, describe in this field
Describe active movements affected by muscle tone	Indicate active movements affected by muscle tone
Describe passive movements affected by muscle tone	Indicate passive movements affected by muscle tone.
Describe reflexes present	Indicate the reflexes present

### Part II - Postural Control (Required for manual and power wheelchairs)

Field Description	Guidelines
Indicate the postural control of the client	Indicate all postural controls for the head, trunk, upper extremity, lower extremity for the client.

### Part III - Medical/Surgical History and Plans (Required for manual and power wheelchairs)

Field Description	Guidelines
Is there a history of	Indicate "yes" or "no"

<b>Field Description</b>	<b>Guidelines</b>
decubitus/skin breakdown	
If yes, explain	If yes, explain
Describe orthopedic conditions and/or range of motion limitations requiring special consideration	Describe orthopedic conditions and/or range of motion limitations requiring special consideration (for example, contractures, spinal curvature)
Describe other physical limitations or concerns	Describe other physical limitations or concerns (for example, respiratory problems)
Describe any recent or expected changes in medical/physical/functional status	Describe any recent or expected changes in medical/physical/functional status
If surgery is anticipated indicate the procedure and expected date	If surgery is anticipated indicate the procedure and expected date

#### **Part IV – Functional Assessment (Required for manual and power wheelchairs)**

<b>Field Description</b>	<b>Guidelines</b>
Ambulatory Status	Indicate the client's ambulatory status
Indicate client's ambulation potential	Indicate the client's ambulation potential
Is client totally dependent upon wheelchair	Indicate "yes" or "no"
If no, explain	If no, explain
Indicate the client's transfer capabilities	Indicate the client's transfer capabilities
Feeding	Indicate the client's feeding capabilities
Is the client tube fed?	Indicate "yes" or "no"
If yes, explain	If yes, explain
Dressing	Indicate the client's dressing capabilities
Describe other activities performed while in wheelchair	Describe other activities performed while in wheelchair

#### **Part V – Environmental Assessment (Required for manual and power wheelchairs)**

<b>Field Description</b>	<b>Guidelines</b>
Describe where client resides	Indicate where the client resides
Is the home accessible to the wheelchair	Indicate "yes" or "no"
Are ramps available in the home setting?	Indicate "yes" or "no"
Describe the client's educational/vocational setting:	Indicate the client's educational/vocational setting:
Is the school accessible to the wheelchair?	Indicate "yes" or "no"
Are ramps available in the school setting?	Indicate "yes" or "no"
If client is in school, has a school therapist been involved in the assessment?	Indicate "yes" or "no"
Name of school	Indicate the client's school name

<b>Field Description</b>	<b>Guidelines</b>
Name of school therapists	Enter the client's school therapists name
School therapists telephone number	Enter the school therapists telephone number
Describe how the wheelchair will be transported	Describe how the wheelchair will be transported
Describe where the wheelchair will be stored	Describe where the wheelchair will be stored
Describe other types of equipment that interface with the wheelchair	Describe other types of equipment that interface with the wheelchair

**Part VI – Requested Equipment (Required for manual and power wheelchairs)**

<b>Field Description</b>	<b>Guidelines</b>
Describe client's current seating system, including the mobility base and the age of the seating system:	Describe client's current seating system, including the mobility base and the age of the seating system
Wheelchair type	Indicate the requested wheelchair type
Serial number	Indicate the requested wheelchair serial number
Date of purchase	Indicate the date of purchase
Describe why current seating system is not meeting the client's needs	Describe why current seating system is not meeting the client's needs
Describe the equipment requested	Describe the equipment requested
Describe the medical necessity for mobility base requested	Describe the medical necessity for mobility base requested
Describe the medical necessity for the seating system requested	Describe the medical necessity for the seating system requested
Describe the growth potential of equipment requested in number of years:	Describe the growth potential of equipment requested in number of years:
Describe any anticipated modifications/changes to the equipment within the next three years:	Describe any anticipated modifications/changes to the equipment within the next three years:
Therapist's name	Enter the therapist's name
Therapist's title	Enter the therapist's title
Therapist's telephone	Enter the therapist's telephone number
Therapist's fax	Enter the therapist's fax number
Therapist's signature	Therapist must sign in this field
Date	Enter the date the form was signed
Therapist's employer	Enter the therapist's employer name
Address/City/State/Zip	Enter the therapist's address, city, state, and ZIP code

**Part VII – Power Wheelchair (Required only for power wheelchairs)**

<b>Field Description</b>	<b>Guidelines</b>
Describe the medical necessity for power vs. manual wheelchair and justify any accessories, such as power tilt	Describe client's current seating system, including the mobility base and the age of the seating system

Field Description	Guidelines
or recline	
Is client unable to operate manual chair even when adapted?	Indicate "yes" or "no"
Is self-propulsion possible, but activity is extremely labored?	Indicate "yes" or "no"
Date of purchase	Indicate the date of purchase
If yes, please explain	If yes, please explain
Is self-propulsion possible, but contrary to treatment regimen?	Indicate "yes" or "no"
If yes, please explain	If yes, please explain
How will the power wheelchair be operated?	Indicate how the power wheelchair will be operated? (hand, chin, etc)
Is the client physically and mentally capable of operating power wheelchair safely and with respect to others?	Indicate "yes" or "no"
Is the caregiver capable of caring for power wheelchair and understanding how it operates?	Indicate "yes" or "no"
How will training for the power equipment be accomplished?	Indicate how training for the power equipment will be accomplished
Therapist's name	Enter the therapist's name
Therapist's title	Enter the therapist's title
Therapist's telephone	Enter the therapist's telephone number
Therapist's fax	Enter the therapist's fax number
Therapist's signature	Therapist must sign in this field
Date	Enter the date the form was signed
Therapist's employer	Enter the therapist's employer name
Address/City/State/Zip	Enter the therapist's address, city, state, and ZIP code

### Measuring Worksheet (Required *only* for power wheelchairs)

Field Description	Guidelines
Date when measured	Enter the date when the client was measured
Print or type measurer's name	Indicate measurer's name
Measurer's telephone	Indicate measurer's telephone number
Client Measurements	Indicate the clients measurements
Additional comments	Indicate any appropriate additional comments

#### Additional Requirements:

- Only one physician signature is required on the CSHCN Services Program wheelchair seating evaluation form.
- Written requests for prior authorization and authorization of all wheelchairs must include the CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME) in addition to this form.
- A physical therapist or an occupational therapist who is not employed by the DME provider must complete the evaluation and the CSHCN Services Program Wheelchair Seating Evaluation Form

- Authorization for wheelchair modifications or repairs for an existing seating system also require the wheelchair seating evaluation
- A current wheelchair seating assessment, conducted by a physical or occupational therapist, must be completed for purchase of or modifications (including new seating systems) to a customized wheelchair.
- Attach manufacturers' price sheet and price quotes.  
***Note:** If a price change occurs after the authorization has been granted, the provider must submit new price sheets with the claim to document the price changes so that the price discrepancy between the authorization and the claim can be manually reviewed.*
- Requests for customized manual and power wheelchairs must include a complete description of the specific base, any attached seating system components and any attached accessories not included in the base price, as well as the retail prices for the individual components, including justification for components that would be considered part of the wheelchair.

# CSHCN Services Program Wheelchair Seating Evaluation Form (page 1 of 6)



Client Information	
First name:	Last name:
CSHCN Services Program number: 9- _____ -00	Date of birth:
Client's height:	Client's weight:
Address/City/State/ZIP:	
Diagnoses (ICD-9-CM):	
Part I – Neurological Factors (Required for manual and power wheelchairs)	
Indicate client's muscle tone: <input type="checkbox"/> Hypertonic <input type="checkbox"/> Absent <input type="checkbox"/> Fluctuating <input type="checkbox"/> Other	
If other, describe client's muscle tone:	
Describe active movements affected by muscle tone:	
Describe passive movements affected by muscle tone:	
Describe reflexes present:	
Part II – Postural Control (Required for manual and power wheelchairs)	
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 extremity:	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> None
Lower extremity:	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> None

# CSHCN Services Program Wheelchair Seating Evaluation Form (page 2 of 6)



Client Information		
First name:	Last name:	
CSHCN Services Program number: 9- _____ -00		
Part III – Medical/Surgical History and Plans (Required for manual and power wheelchairs)		
Is there a history of decubitus/skin breakdown?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, explain:		
Describe orthopedic conditions and/or range of motion limitations requiring special consideration (i.e., contractures, spinal curvature):		
Describe other physical limitations or concerns (i.e., respiratory problem):		
Describe any recent or expected changes in medical/physical/functional status:		
If surgery is anticipated, indicate the procedure and expected date:		
Part IV – Functional Assessment (Required for manual and power wheelchairs)		
Ambulatory Status:	<input type="checkbox"/> Non-ambulatory	<input type="checkbox"/> With assistance
	<input type="checkbox"/> Short distances only	<input type="checkbox"/> Community ambulatory
Indicate client's ambulation potential:	<input type="checkbox"/> Not expected	<input type="checkbox"/> Expected within one year
	<input type="checkbox"/> Expected in future within _____ years	
Is client totally dependent upon wheelchair?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If no, explain:		
List any ambulation aids the client currently uses:		
Indicate the client's transfer capabilities:	<input type="checkbox"/> Maximum assistance	<input type="checkbox"/> Moderate assistance
	<input type="checkbox"/> Minimum assistance	<input type="checkbox"/> Independent
Feeding:	<input type="checkbox"/> Maximum assistance	<input type="checkbox"/> Moderate assistance
	<input type="checkbox"/> Minimum assistance	<input type="checkbox"/> Independent
Is the client tube fed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, explain:		
Dressing:	<input type="checkbox"/> Maximum assistance	<input type="checkbox"/> Moderate assistance
	<input type="checkbox"/> Minimum assistance	<input type="checkbox"/> Independent
Describe other activities performed while in wheelchair:		

# CSHCN Services Program Wheelchair Seating Evaluation Form (page 3 of 6)



Client Information		
First name:	Last name:	
CSHCN Services Program number: 9- _____ -00		
Part V – Environmental Assessment (Required for manual and power wheelchairs)		
Describe where client resides: <input type="checkbox"/> Single story home <input type="checkbox"/> Multi-story home <input type="checkbox"/> Ground floor apartment <input type="checkbox"/> Upper-level apartment <input type="checkbox"/> Mobile home <input type="checkbox"/> Other _____		
Is the home accessible to the wheelchair?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are ramps available in the home setting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Describe the main entrance to the home:		
Are there and barriers to entering or exiting the home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Describe the client's educational/vocational setting:		
Is the school accessible to the wheelchair?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are ramps available in the school setting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If client is in school, has a school therapist been involved in the assessment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Name of school:		
Name of school therapist:	School therapist's telephone number:	
Describe how the wheelchair will be transported:		
Describe where the wheelchair will be stored:		
Describe other types of equipment that interface with the wheelchair:		



# CSHCN Services Program Wheelchair Seating Evaluation Form (page 4 of 6)



Client Information	
First name:	Last name:
CSHCN Services Program number: 9- _____ -00	
Part VI – Requested Equipment (Required for manual and power wheelchairs)	
Describe client’s current seating system, including the mobility base and the age of the seating system:	
Wheelchair type:	
Serial number:	Date of purchase:
Describe why current seating system is not meeting the client’s needs:	
Describe the equipment requested:	
Describe the medical necessity for mobility base requested:	
Describe the medical necessity for the seating system requested:	
Describe the growth potential of equipment requested in number of years:	
Describe any anticipated modifications/changes to the equipment within the next three years:	
Therapist’s name:	Therapist’s title:
Therapist’s telephone:	Therapist’s fax:
Therapist’s signature:	Date:
Therapist’s employer:	
Address/City/State/ZIP:	

# CSHCN Services Program Wheelchair Seating Evaluation Form (page 5 of 6)



**Part VII – Power Wheelchairs (Also complete this part when requesting a power wheelchair) (Required *only* for power wheelchairs)**

Describe the medical necessity for power vs. manual wheelchair and justify any accessories, such as power tilt or recline:


Is client unable to operate manual chair even when adapted?       Yes                                       No

Is self-propulsion possible, but activity is extremely labored?       Yes                                       No

If yes, please explain:


Is self-propulsion possible, but contrary to treatment regimen?       Yes                                       No

If yes, please explain:


How will the power wheelchair be operated? (e.g., hand, chin, etc.)


Is the client physically and mentally capable of operating power wheelchair safely and with respect to others?       Yes                                       No

Is the caregiver capable of caring for power wheelchair and understanding how it operates?       Yes                                       No

How will training for the power equipment be accomplished?


Therapist's name:	Therapist's title:
-------------------	--------------------

Therapist's telephone:	Therapist's fax:
------------------------	------------------

Therapist's signature:	Date:
------------------------	-------

Therapist's employer:

Address/City/State/ZIP:

--

# CSHCN Services Program Wheelchair Seating Evaluation Form (page 6 of 6)

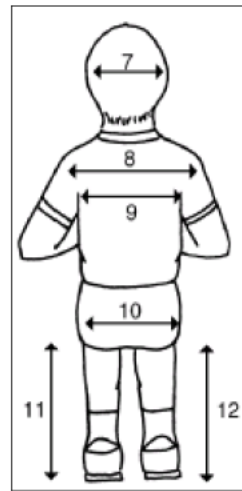
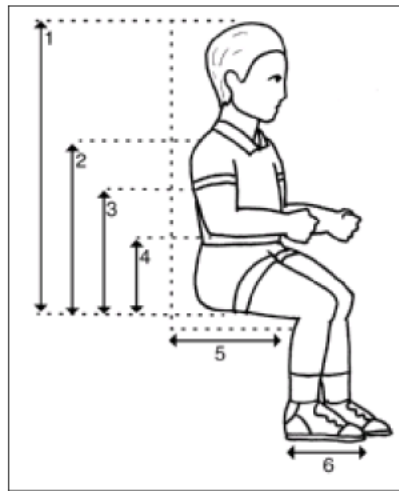


## Client Information

First name:	Last name:
CSHCN Services Program number: 9- _____ -00	

## Measuring Worksheet

Date when measured:	Print or type measurer's name:
Measurer's telephone:	



## Client Measurements

Description	Measure	Description	Measure
1. Top of head to bottom of buttocks		7. Head width	
2. Top of shoulder to bottom of buttocks		8. Shoulder width	
3. Arm pit to bottom of buttocks		9. Arm pit to arm pit	
4. Elbow to bottom of buttocks		10. Hip width	
5. Back of buttocks to back of knee		11. Left leg popliteal to heel	
6. Foot length		12. Right leg popliteal to heel	

## Additional Comments
