NEW HAMPSHIRE MEDICAID

KEPRO INTELLIGENT VALUE

MOBILITY EVALUATION FORM

This evaluation must be completed by a New Hampshire licensed physician, occupational therapist, or physical therapist specializing in rehabilitation medicine. Evaluator must have a broad knowledge of the various seating systems and wheelchairs available in today's market. **NOTE:** Requests for standard/non-customized manual wheelchairs do not require the completion of this form by a physician or OT/PT; a rehabilitation specialist may complete the form.

*****PLEASE PRINT OR TYPE ALL INFORMATION*****

RECIPIENT NAME: _____ **RECIPIENT MEDICAID ID #:** _____

RECIPIENT HEIGHT: _____ **RECIPIENT WEIGHT:** _____

DOES RECIPIENT HAVE ALTERNATE INSURANCE PLAN? ☐ **YES** ☐ **NO**

NAME OF INSURANCE PLAN:_____

PROVIDER INFORMATION

PROVIDER NAME: _____ **NH MEDICAID PROVIDER #:** _____

ADDRESS: _____ **CITY/STATE/ZIP:** _____

TELEPHONE #: _____ **FAX #:** _____

DATE OF EVALUATION: _____/_____/_____ **PLACE OF EVALUATION:** _____

DIAGNOSIS (written, not ICD-9) **PRIMARY:** _____

SECONDARY: _____

If this recipient has had multiple seating systems in the past three (3) years, or surgical procedures are anticipated, or growth or physical deterioration may limit recipient's ability to utilize the proposed seating system for less than five (5) years, then the recipient must be evaluated for an "adjustable growth" seating system that would accommodate any foreseeable changes.

CURRENT AMBULATORY STATUS

Please address the following: Would the recipient be confined to a bed if a wheelchair were not provided? Is the recipient able to use a walker, cane, or walk with assistance? What is the distance the recipient is able to ambulate without assistance?

_____

_____

_____

_____

MEDICAL HISTORY

Please provide dates and names of recent surgical procedures and/or hospitalizations as well as other relevant information.

_____

_____

_____

PLEASE FORWARD THIS INFORMATION TO ATTENTION – KePRO NH MEDICAID BY FAX OR MAIL

Please submit supporting documentation for verification of above information
Approval is a determination that the services requested are medically necessary and not a guarantee of payment.

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CURRENT SEATING SYSTEM

Make: _____ **Model:** _____ **Age/Condition:** _____

PROBLEM WITH CURRENT SEATING SYSTEM:

_____

_____

_____

_____

PLEASE COMMENT ON RECIPIENT'S:

Vision: _____

_____

Cognition: _____

_____

Ability to Communicate: _____

_____

_____

Daily Activity Level: _____

_____

_____

Mobility Evaluation (strength/tone/contractures etc.): _____

_____

_____

_____

Anticipated Surgical Procedures/Orthotics: _____

_____

_____

_____

Other Special Considerations: _____

_____

_____

_____

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PLEASE INDICATE WHICH LESS COSTLY WHEELCHAIRS/SEATING SYSTEMS HAVE BEEN CONSIDERED AND WHY THEY WOULD NOT BE APPROPRIATE TO MEET THIS RECIPIENT'S NEEDS. (attach additional comments As necessary):

_____

_____

_____

_____

_____

_____

TO BE COMPLETED BY PERSON PERFORMING THE EVALUATION

THE FOLLOWING OPTIONS ARE MEDICALLY NECESSARY:

	Option	Justification
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
8.	_____	_____
9.	_____	_____
10.	_____	_____
11.	_____	_____
12.	_____	_____
13.	_____	_____
14.	_____	_____
16.	_____	_____
17.	_____	_____
18.	_____	_____

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RECOMMENDED CHAIR

Make: _____ Model: _____

Check all that apply. Indicate N/A if not applicable:

- ☐ Will allow access to recipient's home
- ☐ Will allow access to school/place of employment
- ☐ Will meet van/bus/other transportation methods recipient currently needs
- ☐ Will meet recipient's mobility needs
- ☐ Potential growth of recipient has been taken into consideration in selecting the size of chair so that it may provide at least **five (5) years of use**
- ☐ Recipient's caregivers are familiar with care /maintenance/operation of this chair
- ☐ Recipient has demonstrated proficiency in the safe operation of this chair
- ☐ Less costly chairs have been ruled out as inappropriate
- ☐ This chair will accommodate recipient's respiratory equipment and other special needs

SUMMARY / COMMENTS

_____

_____

_____

_____

_____

_____

_____ _____

Signature of physician, licensed therapist or rehab specialist (non-custom. only) completing the evaluation Date

_____

Printed name of physician, licensed therapist or rehab specialist (for non custom. only) completing the evaluation

INDIVIDUALS PRESENT DURING EVALUATION:

1) _____ Representing/Relationship to recipient: _____

2) _____ Representing/Relationship to recipient: _____

3) _____ Representing/Relationship to recipient: _____

4) _____ Representing/Relationship to recipient: _____

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RECIPIENT, PARENT OR LEGAL GUARDIAN (please check the statement that applies)

☐ I **accept** the recommendations for the make, model and options of the equipment being requested and acknowledge that the safe operation and benefits of the equipment's options and features have been fully explained to me. I have no questions or concerns regarding the recommendations made.

☐ I **do not agree** with all of the recommendations and I request changes based on the following:

_____

_____

_____

_____ _____ _____

Signature of Recipient/Parent/Legal Guardian | Relationship | Date

WHEELCHAIR SUPPLIER (Please check all of the following statements that apply. If a statement does not apply, please state why they do not apply in the comments section below)

☐ I concur with the recommendations made, and I am unaware of any other less costly wheelchairs or options in the market at this time that would meet this recipient's needs.

☐ The recipient ☐ **is** ☐ **is not** a nursing facility resident or awaiting placement to a nursing facility.

☐ The recipient is a nursing facility resident but is awaiting discharge.

☐ To the best of my knowledge, the recipient ☐ **has** ☐ **has not** received, nor is expected to receive, a wheelchair (seating system) from other sources.

☐ To the best of my knowledge, the recipient ☐ **does** ☐ **does not** have insurance or funding sources for this seating system.

☐ The chair being requested ☐ **is** ☐ **is not** a backup seating system to any current mobility system the recipient now has or is expected to obtain.

☐ Any and all components (i.e. cushions, trays, headrests) that can be utilized from the recipient's current wheelchair will be placed on the new wheelchair.

☐ I have visited the recipient's home and have verified that the home may be accessed using this wheelchair (including bedroom, bath, and other living spaces as needed).

☐ I recommend consideration of the equipment changes as listed below:

_____

_____

_____

_____

By signing below, the selected wheelchair vendor acknowledges that the NH Medicaid payment for the wheelchair to the vendor is **inclusive** of the following services: 1. **Delivery** and assembly of the chair; 2. E**xplanation** as to the proper care and preventive maintenance of the chair; 3. **Demonstration** as to the chair's proper operating procedure; and 4. Any necessary **follow-up for training** and/or **adjustments** required for the chair within 30 days following the delivery of the chair.

_____ _____

Signature of wheelchair vendor | Date

_____ _____

Printed name of wheelchair vendor | Name of wheelchair vendor's company

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2810 N. Parham Rd. ■ Suite 305 ■ Henrico, VA 23294 ■ FAX: (800) 922-9847 ■ PHONE: (800) 299-5921