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.
- **Complete all sections of this form.**
- Print or type all information.
- Contact the TMHP-CSHCN Services Program Contact Center at 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 #100 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)," in the current *CSHCN Services Program Provider Manual*.

Prior Authorization Request Submitter Certification Statement

Description
Read the certification statement and select "We Agree."

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
Diagnoses	Enter the diagnosis code(s) 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
Is there a history of decubitus/skin breakdown	Indicate "yes" or "no"
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)

Field Description	Guidelines
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)

Field Description	Guidelines
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	Indicate "yes" or "no"

Field Description	Guidelines
in the assessment?	
Name of school	Indicate the client's school name
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)

Field Description	Guidelines
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 o*nly* for power wheelchairs)

Field Description	Guidelines
Describe the medical necessity for power vs. manual	Describe client's current seating system, including the mobility base and the age of the seating system

Field Description	Guidelines
wheelchair and justify any accessories, such as power tilt 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 7)

Prior Authorization Request Submitter Certification Statement

I certify and affirm that I am either the Provider, or have been specifically authorized by the Provider (hereinafter "Prior Authorization Request Submitter") to submit this prior authorization request.

The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that they are personally acquainted with the information supplied on the prior authorization form and any attachments or accompanying information and that it constitutes true, correct, complete and accurate information; does not contain any misrepresentations; and does not fail to include any information that might be deemed relevant or pertinent to the decision on which a prior authorization for payment would be made.

The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that the information supplied on the prior authorization form and any attachments or accompanying information was made by a person with knowledge of the act, event, condition, opinion, or diagnosis recorded; is kept in the ordinary course of business of the Provider; is the original or an exact duplicate of the original; and is maintained in the individual patient's medical record in accordance with the *CSHCN Services Program Provider Manual*.

The Provider and Prior Authorization Request Submitter certify and affirm that they understand and agree that prior authorization is a condition of reimbursement and is not a guarantee of payment.

The Provider and Prior Authorization Request Submitter understand that payment of claims related to this prior authorization will be from Federal and State funds, and that any false claims, statements or documents, concealment of a material fact, or omitting relevant or pertinent information may constitute fraud and may be prosecuted under applicable federal and/or State laws. The Provider and Prior Authorization Request Submitter understand and agree that failure to provide true and accurate information, omit information, or provide notice of changes to the information previously provided may result in termination of the provider's CSHCN Services Program enrollment and/or personal exclusion from the CSHCN Services Program.

The Provider and Prior Authorization Request Submitter certify, affirm and agree that by checking "We Agree" that they have read and understand the Prior Authorization Agreement requirements as stated in *the CSHCN Services Program Provider Manual* and they agree and consent to the Certification above and to the Texas Medicaid & Healthcare Partnership (TMHP) Terms and Conditions.

☐ We Agree

CSHCN Services Program Wheelchair Seating Evaluation Form (page 2 of 7)

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:	

Part I – Neurological Factors (Required for manual and power wheelchairs)
Indicate client's muscle tone: ☐ Hypertonic ☐ Absent ☐ Fluctuating ☐ 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:	☐ Good	☐ Fair	☐ Poor	☐ None
Trunk control:	☐ Good	☐ Fair	☐ Poor	☐ None
Upper extremity:	☐ Good	☐ Fair	☐ Poor	☐ None
Lower extremity:	☐ Good	☐ Fair	☐ Poor	☐ None

CSHCN Services Program Wheelchair Seating Evaluation Form (page 3 of 7)

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?	☐ Yes	☐ 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:	☐ Non-ambulatory	☐ With assistance
	☐ Short distances only	☐ Community ambulatory
Indicate client's ambulation potential:	☐ Not expected	☐ Expected within one year
	☐ Expected in future within _____ years	
Is client totally dependent upon wheelchair?	☐ Yes	☐ No
If no, explain:		
List any ambulation aids the client currently uses:		
Indicate the client's transfer capabilities:	☐ Maximum assistance	☐ Moderate assistance
	☐ Minimum assistance	☐ Independent
Feeding:	☐ Maximum assistance	☐ Moderate assistance
	☐ Minimum assistance	☐ Independent
Is the client tube fed?	☐ Yes	☐ No
If yes, explain:		
Dressing:	☐ Maximum assistance	☐ Moderate assistance
	☐ Minimum assistance	☐ Independent
Describe other activities performed while in wheelchair:		

CSHCN Services Program Wheelchair Seating Evaluation Form (page 4 of 7)

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: ☐ Single story home ☐ Multi-story home ☐ Ground floor apartment ☐ Upper-level apartment ☐ Mobile home ☐ Other _____			
Is the home accessible to the wheelchair?		☐ Yes	☐ No
Are ramps available in the home setting?		☐ Yes	☐ No
Describe the main entrance to the home:			
Are there and barriers to entering or exiting the home?		☐ Yes	☐ No
Describe the client's educational/vocational setting:			
Is the school accessible to the wheelchair?		☐ Yes	☐ No
Are ramps available in the school setting?		☐ Yes	☐ No
If client is in school, has a school therapist been involved in the assessment?		☐ Yes	☐ 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 5 of 7)

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:	

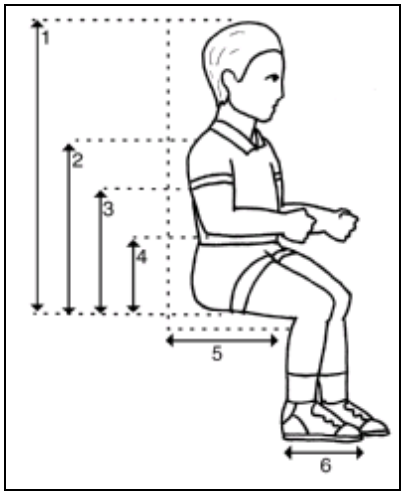
CSHCN Services Program Wheelchair Seating Evaluation Form (page 6 of 7)

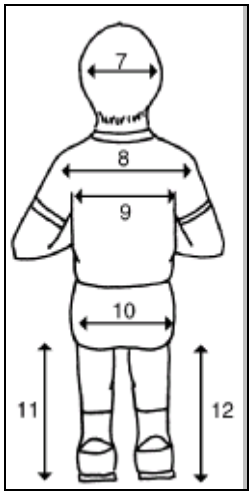
Part VII – Power Wheelchairs (Also complete this part when requesting a power wheelchair) (Required *only* for power wheelchairs)		
Describe the medical necessity for power vs. manual wheelchair and justify any accessories, such as power tilt or recline:		
Is client unable to operate manual chair even 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 7 of 7)

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