DLN _____ Medicaid ID _____ Individual Name _____

Authorization Request for Nursing Facility Specialized Services (NFSS)

NFSS for Customized Manual Wheelchair (CMWC)

Resident/NF

Resident Information

A0100A. First Name	A0100B. Middle Initial	A0100C. Last Name	A0100D. Suffix	A0200A. Social Security No.

A0200B. Medicare No.	A0300. Medicaid No.	A0400A. Birth Date	A0400B. Age at Time of Submission

Legally Authorized Representative (LAR) Information

A0500A. First Name	A0500B. Last Name

A0600A. Street Address	A0600B. City	A0600C. State	A0600D. ZIP Code

A0600E. Phone No.

For Reference Only, Not to be Faxed to the State or TMHP

Nursing Facility Information

A0700A. Provider No.	A0700B. Vendor No.	A0700C. NPI/API No.

A0700D. Facility Name	A0800A. Street Address	A0800B. City

A0800C. State	A0800D. ZIP Code	A0800E. County	A0900A. Phone No.	A0900B. Fax No.

LIDDA and LMHA Information

A1000A. LIDDA Provider No.	A1000B. LIDDA Vendor No.	A1000C. LIDDA NPI/API No.

A1100A. LMHA Provider No.	A1100B. LMHA Vendor No.	A1100C. LMHA NPI/API No.

Type of Service Requested

A2000. Request Type	Customized Manual Wheelchair (CMWC)
A2100. CMWC Service Type (Select only one)	☐ 1. CMWC Assessment Only 2. CMWC

DLN _____ Medicaid ID _____ Individual Name _____

CMWC Assessment

Therapist Identifying Information

B0100A. First Name

B0100B. Last Name

B0200A. License Type (Select only one)

- ☐ 1. Occupational
- ☐ 2. Physical

B0200B. License No.

B0200C. License State

B0300. Is the Therapist employed by the Nursing Facility?

- ☐ 0. No
- ☐ 1. Yes

If the Therapist is not employed by the Nursing Facility complete the remainder of **Therapist Identifying Information** section.

For Reference Only, Not to be Faxed to the State or TMHP

B0400. Therapist's Employer Name

B0500A. Street Address

B0500B. City

B0500C. State

B0500D. ZIP Code

B0600A. Phone No.

B0600B. FAX No.

B0700. Therapist's Signature Date

To be entered from Attachment CMWC DME Signature Page.

Date of Assessment

B0800. Date of Assessment

Postural Control

B0900A. Head Control (Select one)

B0900B. Trunk Control (Select one)

B0900C. Upper Extremities (Select one)

B0900D. Lower Extremities (Select one)

- ☐ 1. Good
- ☐ 2. Fair
- ☐ 3. Poor
- ☐ 4. None

Medical Surgical History and Plan

B1000A. Is there a history of decubitus/skin breakdown?

- ☐ 0. No
- ☐ 1. Yes

B1000B. If Yes, explain (minimum of 50 characters)

B1100A. Is there current decubitus/skin breakdown? ☐ 0. No 1. Yes

For Reference Only, Not to be Faxed to the State or TMHP.

B1100B. If Yes, explain and include the wound stage and dimensions of each current site (minimum of 50 characters):

B1200. Describe orthopedic conditions and/or range of motion limitations requiring special consideration (e.g. contractures, degree of spinal curvature, etc.):

B1300. Describe other physical limitations or concerns (i.e., respiratory):

B1400. Describe any recent or expected changes in medical/physical/functional status:

For Reference Only, Not to be Faxed to the State or TMHP.

B1500A. Is surgery anticipated? ☐ 0. No 1. Yes

B1500B. If Yes, indicate the expected date

B1500C. If Yes, describe the procedure (minimum of 50 characters):

Neurological Factors

B1600A. Indicate resident's muscle tone (Select only one):

- ☐ 1. Absent
- 2. Fluctuating
- 3. Hypertonic
- 4. Other

B1600B. Describe resident's muscle tone (minimum of 50 characters):

B1600C. Describe active movements affected by muscle tone (minimum of 50 characters):

For Reference Only, Not to be Faxed to the State or TMHP.

B1600D. Describe passive movements affected by muscle tone (minimum of 50 characters):

B1600E. Describe reflexes present (minimum of 50 characters):

For Reference Only, Not to be Faxed to the State or TMHP.

Functional Assessment

B1700A. Ambulatory Status (Select only one):
1. Community ambulatory
2. Non-ambulatory
3. Short distances up to ___ feet
4. With assistance

B1700B. No. of Feet

If Ambulatory Status is Short distance provide number of feet.

B1700C. Is the resident dependent upon a wheelchair or walker for ambulation?
0. No
1. Yes

B1700D. If Yes, describe the level of dependence. If no, describe the resident's ability to ambulate. (minimum of 50 characters)

B1800A. Indicate ambulation potential (Select only one):

- ☐ 1. Not expected
- ☐ 2. Expected within 1 year
- ☐ 3. Expected in the future

B1800B. No. of years (Select only one):

If ambulation potential is expected in the future, enter the number of years.

- ☐ 1. 1 year
- ☐ 2. 2 years
- ☐ 3. 3 years
- ☐ 4. 4 years
- ☐ 5. 5 years

For Reference Only, Not to be Faxed to the State or TMHP.

B2000. Feeding (Select only one):

- ☐ 1. Maximum assistance
- ☐ 2. Moderate assistance
- ☐ 3. Minimum assistance
- ☐ 4. Independent

B2100A. Is the resident tube fed?

- ☐ 0. No
- ☐ 1. Yes

B2100B. If yes, explain (minimum of 50 characters)

B2200. Dressing (Select only one)
1. Maximum assistance
2. Moderate assistance
3. Minimum assistance
4. Independent

Educational/Vocational Setting

B2300A. Does the resident have a current education/vocational setting?
0. No
1. Yes

B2300B. If Yes, Name of educational/vocational site:

B2300C. If Yes, has the therapist from the educational/vocational setting been involved in this assessment?
0. No
1. Yes

B2310. Other Therapist from Education/ Vocational Setting

B2310A. First Name	B2310B. Last Name	B2310C. Phone No.

For Reference Only, Not to be Faxed to the State or HHSC.

Referring Physician Identifying Information

To be completed by the Physician if Authorization Type is CMWC.
Skip if Authorization Type is Assessment Only.

B2400A. Last Name	B2400B. License State	B2400C. License No.	B2400D. Military Spec Code

B2400E. Date Resident Last Seen	B2400F. Signature Date

To be entered from the Attachment CMWC DME Signature Page

Note: The following Physician information is required if Physician is not licensed in Texas.

B2500. First Name

B2600A. Street Address

B2600B. City

B2600C. State	B2600D. ZIP Code	B2600E. Phone No.

DLN _____ Medicaid ID _____ Individual Name _____

CMWC Request

Complete only if Type of Service is CMWC.

Current Seating Equipment

C0100A. Does the resident have a current seating system? ☐ 0. No 1. Yes

If No, Skip to Requested Customized Seating Equipment.
If Yes, complete the following:

C0100B. Describe the resident's current seating system, including the mobility base and age of the system/base. (minimum of 50 characters)

For Reference Only, Not to be Faxed to the State or TMHP.

C0100C. Describe wheelchair type (minimum of 50 characters):

C0100D. Date of Purchase

C0100E. Describe why the current seating system does not meet the resident's needs. (minimum of 50 characters)

Requested Customized Seating Equipment

C0200. Describe the seating system that is being requested and how it must be customized to meet the resident's specific medical needs. (minimum of 50 characters)

For Reference Only, Not to be Faxed to the State or TMHP.

C0300. Describe the mobility base that is being requested. (minimum of 50 characters)

C0400. Describe the medical necessity for the requested customized seating system. (minimum of 50 characters)

C0500. Describe any anticipated modifications/changes to the requested equipment within the next five years. (minimum of 50 characters)

For Reference Only, Not to be Faxed to the State or TMHP.

C0600. Describe other activities performed while in the CMWC. (minimum of 50 characters)

DLN _____ Medicaid ID _____ Individual Name _____

Measuring Worksheet

C0700. Measurements Completed By:	C0700A. First Name	C0700B. Last Name	C0700C. Title
C0800. Measurements	C0800A. Measurement Date	C0800B. Height (in inches)	C0800C. Weigh (in pounds)

All Measurements should be recorded in inches.

C0900A.	Top of head to bottom of buttocks.....	
C0900B.	Top of shoulder to bottom of buttocks.....	
C0900C.	Armpit to bottom of buttocks.....	
C0900D.	Elbow to bottom of buttocks.....	
C0900E.	Back of buttocks to back of knee.....	
C0900F.	Foot length.....	
C0900G.	Head width.....	
C0900H.	Shoulder width.....	
C0900I.	Armpit to armpit.....	
C0900J.	Hip width.....	
C0900K.	Distance to bottom of left leg (popliteal to heel).....	
C0900L.	Distance to bottom of right leg (popliteal to heel).....	

For Reference Only, Not to be Faxed to the State or TMHP.

C0900M. Additional Comments/Observations

DLN _____ Medicaid ID _____ Individual Name _____

Environmental Assessment

C1000. Is the resident's living environment accessible and safe for the use of the CMWC requested? ☐ 0. No 1. Yes

C1100A. Will the CMWC need to be transported? ☐ 0. No 1. Yes

C1100B. If Yes, describe how the item will be transported. (minimum of 50 characters)

For Reference Only, Not to be Faxed to the State or TMHP.

If the resident does not have a current education/vocational setting skip to Supplier Information and MSRP Quote.
If the resident has a current education/vocational setting complete this section.

C1200. Is the educational/vocational site accessible to the requested CMWC? ☐ 0. No 1. Yes

C1300. Are ramps available by the educational/vocational site? ☐ 0. No 1. Yes

C1400. Additional comments and observations of educational vocational therapist:

DLN _____ Medicaid ID _____ Individual Name _____

Supplier Information and MSRP Quote

Supplier Information

C1500. Supplier's Business Name

C1600. Supplier's Representative Completing Form | C1600A. First Name | C1600B. Last Name

C1700A. Street Address | C1700B. City | C1700C. State

C1700D. ZIP Code | C1800A. Phone No. | C1800B. FAX No.

Itemized Manufacturer's Suggested Retail Price (MSRP) Quote

C1900B. Item No.	C1900C. HCPCS Code	C1900D. Description of Item	C1900E. Item Price*	C1900F. Quantity	C1900G. Total Price	C1900H. Approved Price
1					$	$
2					$	$
3					$	$
4					$	$
5					$	$
6					$	$
7					$	$
8					$	$
9					$	$
10					$	$
11					$	$
12					$	$
13					$	$
14					$	$
15					$	$

Form cannot be Faxed to the State or TMHP.

DLN _____ Medicaid ID _____ Individual Name _____

C1900B. Item No.	C1900C. HCPCS Code	C1900D. Description of Item	C1900E. Item Price*	C1900F. Quantity	C1900G. Total Price	C1900H. Approved Price
16					$	$
17					$	$
18					$	$
19					$	$
20					$	$
21					$	$
22					$	$
*Item Price must be based on MSRP.			C1900I. Total Amount of All Items Requested		1.$	2.$
			C1900J. Minus 18%		1.$	2.$
			C1900K. Grand Total		1.$	2.$

For Reference Only, Not to be Faxed to the State or

Receipt Certification

Upon receipt of a CMWC, the authorizing therapist must verify that the CMWC meets the needs of the individual and that the specifications are as intended in accordance with HHSC rules and policies.

Therapist Certification of Delivered CMWC

By signing the Attachment CMWC/DME Receipt Certification, the therapist is certifying that the CMWC meets the needs of the individual and that the specifications are as intended in accordance with HHSC rules and policies.

C4300. Therapist's Name — A. First Name _____ B. Last Name _____

C4400. Therapist's License — A. License Type ☐ 1. Occupational ☐ 2. Physical — B. License No. _____

C4500. Therapist's Certification Date _____

NF Administrator Certification of Delivered CMWC

By signing the Attachment CMWC/DME Receipt Certification, the NF Administrator is attesting that the CMWC has been delivered as prescribed in the assessment to an individual who is a resident in the facility.

C4600. NF Administrator's Name — A. First Name _____ B. Last Name _____

C4700. CMWC Received Date _____

C4800. NF Administrator's Certification Date _____