Nursing Facility Customized Power Wheelchair (CPWC) Authorization

Is this submission a request to transfer the authorization of a CPWC to a new facility? ☐ Yes ☐ No
(If **Yes**, complete **only Sections A, B, F and G** and submit the form.)

Section A. Resident-Related Identifying Information

Resident's Name	Resident's Medicaid No.	Date of Birth	Is resident age 21 or older? ☐ **Yes** ☐ **No**
Name of Nursing Facility			
Nursing Facility Address		City, State, ZIP Code	
Resident's Legally Authorized Representative (LAR) Name		Resident's LAR Area Code and Telephone No.	
Resident's LAR Address		City, State, ZIP Code	

Section B. Nursing Facility Identifying Information

Nursing Facility Name	HHSC Contract No.	NPI No.
Nursing Facility Address	City, State, ZIP Code Cade	
Primary Contact Name and Position	Area Code and Telephone No.	Nursing Facility Area Code and Fax No.

Section C. Therapist Identifying Information and CPWC Assessment

Therapist's Name and Title		☐ Occupational Therapist ☐ Physical Therapist
Is therapist employed by the nursing facility? ☐ Yes ☐ No		
Therapist's Area Code and Telephone No.	Therapist's Area Code and Fax No.	Therapist's Employer Name
Mailing Address		City, State, ZIP Code Cade

CPWC Assessment (Completed by Therapist)

I. Neurological Factors

Indicate resident's muscle tone: ☐ Hypertonic ☐ Absent ☐ Fluctuating ☐ Other
Describe resident's muscle tone:
Describe active movements affected by muscle tone:
Describe passive movements affected by muscle tone:

Resident Name:

Describe reflexes present:

II. Postural Control

Head Control	☐ Good	☐ Fair	☐ Poor	☐ None
Trunk Control	☐ Good	☐ Fair	☐ Poor	☐ None
Upper Extremities	☐ Good	☐ Fair	☐ Poor	☐ None
Lower Extremities	☐ Good	☐ Fair	☐ Poor	☐ None

III. Medical Surgical History and Plans

Is there a *history* of decubitus/skin breakdown? ☐ Yes ☐ No

If Yes, explain:

Is there a c*urrent* decubitus/skin breakdown? ☐ Yes ☐ No

If yes, explain and include the wound stage and wound dimensions of each current site:

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

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

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

If surgery is anticipated, indicate the procedure and expected date:

Resident Name:

IV. Functional Assessment

Ambulatory Status .... ☐ Nonambulatory ☐ With assistance ☐ Short distance only ☐ Community ambulatory

Indicate the resident's ambulation potential (residents who ambulate more than 10 feet independently do not qualify for a CPWC):

☐ Expected within 1 year ☐ Not expected ☐ Expected in the future within _____ years

Can the resident use a modified manual wheelchair for mobility? .... ☐ Yes ☐ No

If Yes, justification must be provided for the requested CPWC.

Is the resident totally dependent upon a wheelchair? .... ☐ Yes ☐ No

If Yes, explain.

Indicate the resident's transfer capabilities:

☐ Maximum assistance ☐ Moderate assistance ☐ Minimum assistance ☐ Independent

Is the resident tube fed? .... ☐ Yes ☐ No

If Yes, explain.

Feeding:

☐ Maximum assistance ☐ Moderate assistance ☐ Minimum assistance ☐ Independent

Dressing:

☐ Maximum assistance ☐ Moderate assistance ☐ Minimum assistance ☐ Independent

Describe other activities performed while in the CPWC. Describe access to equipment while in the CPWC to include any equipment that may be mounted or adapted to the CPWC (i.e., augmented communication device, other):

V. Environmental Assessment

Is the resident's living environment accessible to the CPWC? .... ☐ Yes ☐ No

Are ramps available in the resident's setting? .... ☐ Yes ☐ No

If applicable, identify and describe the resident's current and potential for participation in an educational or vocational setting.

Resident Name:

If there is a current or potential education/vocational setting identified above, complete Items a. – e.

a. Name of education/vocational site: ______________________________

b. Is the site accessible to the requested CPWC?: .... ☐ Yes ☐ No

c. Are ramps available?: .... ☐ Yes ☐ No

d. Has a therapist from the educational/vocational setting been involved in this assessment?:.......... ☐ Yes ☐ No

e.

Name of Therapist	Area Code and Telephone No.

Complete the remaining items for all CPWC requests.

Describe special accommodations required to charge the energy source for the CPWC (nursing facility and/or educational/vocational setting).

Describe how the CPWC will be transported.

Describe where the CPWC will be stored (nursing facility and/or educational/vocational setting).

Describe other types of equipment that will interface with the CPWC (nursing facility and/or educational/vocational setting).

VI. Requested Equipment

Describe the resident's current seating system, including the age of the system.

Describe the resident's current power mobility base and the age of the base.

Resident Name:

Wheelchair Type	Manufacturer
Serial No.	Date of Purchase

Describe why the current seating system does not meet the resident's needs.
Describe the seating system that is being requested and how it must be customized to meet the resident's specific medical needs.
Describe the power mobility base that is being requested.
Describe the medical necessity for the requested seating system and power mobility base.
Describe any anticipated modifications/changes to the equipment within the next five years.

VII. Customized Power Wheelchair

Describe the medical necessity for CPWC and justify any accessories such as a power tilt or recline.
Is self-propulsion possible but activity is extremely labored?.......... ☐ Yes ☐ No If Yes, explain.

Resident Name:

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

If Yes, explain.

How will the CPWC be operated (i.e., hand, chin, puff, etc.)? ***Note:*** *The resident must be able to operate the power mobility system without an attendant control.*

Is a stop switch requested? ☐ Yes ☐ No

If Yes, explain.

Has the resident been evaluated with the drive controls proposed in this request? ☐ Yes ☐ No

Does the resident have any conditions that will necessitate possible change in access or drive controls within the next five years? ☐ Yes ☐ No

If Yes, explain.

Is the resident physically and mentally capable of operating a CPWC safely with respect to other people in the environment? ☐ Yes ☐ No

If No, what additional training is required before the resident can become independently mobile in the CPWC?

With training, is the caregiver capable of caring for and understanding how the requested CPWC will operate? ☐ Yes ☐ No

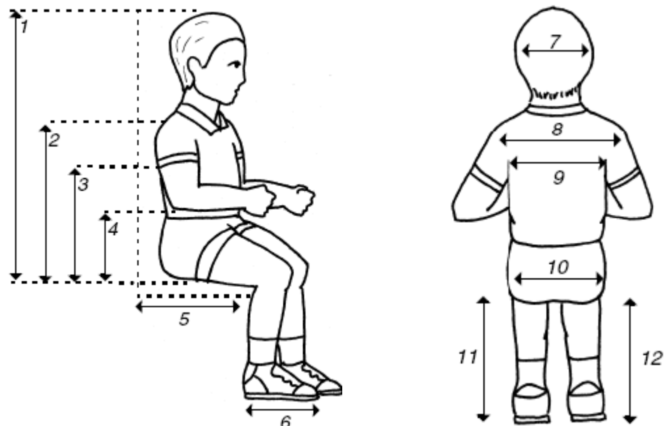
If No, what additional training or arrangements must be made?

How will training for the power equipment be accomplished? (Include the resident, caregiver(s), educational/vocational staff and others.)

Resident Name:

VIII. Measuring Worksheet (Must be Completed by the Physical or Occupational Therapist)

Resident Name				Measurement Date
Height	HT* Range	Weight	WT* Range	Measurements Completed by:
* HT and WT Range = –/+ 20%				
(Request adult figures/diagrams)				



1. Top of head to bottom of buttocks................................______________
2. Top of shoulder to bottom of buttocks..........................______________
3. Arm pit to bottom of buttocks......................................______________
4. Elbow to bottom of buttocks..______________
5. Back of buttocks to back of knee................................______________
6. Foot length ....______________
7. Head width ....______________
8. Shoulder width..______________
9. Arm pit to arm pit..______________
10. Hip width ....______________
11. Distance to bottom of left leg (popliteal to heel) ....______________
12. Distance to bottom of right leg (popliteal to heel) ....______________

Additional Comments/Observations:

IX. Certification by Therapist Completing CPWC Assessment (including Section VIII, Measurement Worksheet)

Therapist's Name (Printed)	Therapist License Type and License No.
Signature – Therapist	Date

Resident Name:

Section D. Supplier Information

Supplier's Business Name	Area Code and Telephone No.
Supplier's Representative Completing Form	Area Code and Fax No.
Address	City, State, ZIP Code

Item No.	HCPCS Code	Description of Item	Item Price	Quantity	Total Price
1					$
2					$
3					$
4					$
5					$
6					$
7					$
8					$
9					$
10					$
11					$
12					$
13					$
14					$
15					$
16					$
17					$
18					$
19					$
20					$
21					$
22					$
				Total Amount of All Items Requested	**$**

Supplier Certification and Acknowledgement

1. I certify the services and items being supplied under this order are consistent with the CPWC assessment for this resident and that the requested items are appropriate and can be used safely in the resident's environment when used as described in the CPWC assessment.
2. I understand that as the supplier, I will be reimbursed in accordance with pricing guidelines of the state Medicaid program for durable medical equipment (DME) and that as the supplier, I will not be paid more than the amount authorized. **The prices listed above are MSRP and I understand that the actual authorized amount for this item is based on MSRP cost minus 18%.**
3. I acknowledge that as the supplier, I will not seek additional reimbursement than the amount authorized. I will not seek or accept any additional payment from the nursing facility, resident or resident's responsible party or other party for the CPWC. **I also acknowledge that modifications and adjustments required within the first six months of delivery of the CPWC are covered within the authorized amount.**
4. I certify the weight capacity of the requested CPWC is _____ pounds.
5. I certify that none of the items listed above are used or refurbished equipment.

Resident Name:

Name of Supplier Representative (Printed)		If Contracted Medicaid or Medicare DME Provider, enter National Provider Identifier (NPI):
Signature – Supplier Representative	Date	

Section E. Physician-Related Information/Prescription

Note: Item No. = from Section D, Supplier Information

Diagnosis (DX) and Medical Necessity (MN) Information

Item No.	ICD-9 Code	Brief Descriptor	MN Justification for Item
1			
2			
3			
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22			

Functionality/mobility status statement by physician:

Resident Name:

Physician's Attestation of MN for Requested CPWC (Note: "Date Last Seen" and "Duration of Need" Items must be provided.)

Date Last Seen by Physician	Duration of Need for CPWC Month(s) or years	
By signing this form, I hereby attest that the information provided in Section E is consistent with the determination of the resident's current medical necessity and prescription. By prescribing the identified CPWC, I certify the prescribed items are appropriate and can be safely used in the resident's environment when used as prescribed.		
Signature/Attestation – Physician		Signature Date
Physician's License No.	Physician's TPI	Physician's NPI

Section F. Transfer Request and Medical Professional Attestation

I. I am formally requesting that the existing customized power wheelchair authorization for ______________________________________ be transferred from his/her previous nursing facility to the facility named in Section B of this form. He/she transferred to this facility as of ______________________, is currently residing in this facility and will be receiving delivery of his/her CPWC at this location.

Name of Facility's Primary Contact (Printed)	Signature – Facility's Primary Contact
Title of Facility's Primary Contact	Signature Date

II. CPWC Medical Professional Certification: The medical professional certifying the statements below must be the resident's physician, an occupational therapist or a physical therapist.

I certify the following:

- The resident's living environment is accessible to the CPWC.
- There are ramps available in the resident's living environment.
- The services and items being supplied under this order are consistent with the CPWC assessment contained in the original form submitted for this resident and that the requested items are appropriate and can safely be used in the resident's environment when used as described in the CPWC assessment.

Medical Professional's Name (Printed)	Type of Medical Professional/Title
Signature – Medical Professional	Signature Date

Section G: Acknowledgement and Signature of Nursing Facility Administrator for Initial Submissions and Transfer Requests

I acknowledge that I have been made aware of the resident's DME request. I understand the appropriate facility staff or contract therapist provided the resident assessment information included in this request to support the resident's needs specific to the requested item.

Name of Nursing Facility Administrator (Printed)

____ ______________________
Signature – Nursing Facility Administrator Date