# Wheelchair/Scooter/Stroller Seating Assessment Form (CCP/Home Health Services) (7 pages)

| Instructions |
|---|
| A current wheelchair/scooter/stroller seating assessment conducted by a physician or a physical or occupational therapist must be completed for purchase of or major modifications (including new seating systems) to a wheeled mobility system. A Qualified Rehabilitation Professional (QRP) must be present and participate in the seating assessment for all wheeled mobility systems and major modifications.<br><br>Please attach manufacturer information, descriptions, and an itemized list of retail prices of all additions that are not included in base model price.<br><br>Complete Sections I-VII for manual wheeled mobility systems. Complete Sections I-IX for power wheeled mobility systems. Complete the Home Health/CCP Measuring Worksheet for all requests. |

| Client Information | |
|---|---|
| First name: | Last name: |
| Medicaid number: | Date of birth: |
| Diagnosis: | |
| Height: | Weight: |

| I. Neurological Factors |
|---|
| Indicate client's muscle tone: ☐ Hypertonic ☐ Absent ☐ Fluctuating ☐ Other |
| Describe client's muscle tone: |
| Describe active movements affected by muscle tone: |
| Describe passive movements affected by muscle tone: |
| Describe reflexes present: |


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| **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 history of decubitis/skin breakdown? ☐ Yes ☐ No<br>*If yes, please explain:* |
| 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, please indicate the procedure and expected date: |

| **IV. Functional Assessment:** | | |
|---|---|---|
| Ambulatory status: | ☐ Nonambulatory | ☐ With assistance |
| | ☐ Short distances only | ☐ Community ambulatory |
| Indicate the client's ambulation potential: | ☐ Expected within 1 year | |
| | ☐ Not expected | |
| | ☐ Expected in future within ___ years | |

| **IV. Functional Assessment:** | | |
|---|---|---|
| Wheelchair Ambulation:<br>Is client totally dependent upon wheelchair? ☐ Yes ☐ No<br>*If no, please explain:* | | |
| Indicate the client's transfer capabilities: | ☐ Maximum assistance<br>☐ Minimum assistance | ☐ Moderate assistance<br>☐ Independent |
| Is the client tube fed? ☐ Yes ☐ No<br>*If yes, please explain:* | | |
| Feeding: | ☐ Maximum assistance<br>☐ Minimum assistance | ☐ Moderate assistance<br>☐ Independent |
| Dressing: | ☐ Maximum assistance<br>☐ Minimum assistance | ☐ Moderate assistance<br>☐ Independent |
| Describe other activities performed while in wheelchair: | | |

| **V. Environmental Assessment** | | |
|---|---|---|
| Describe where client resides: | | |
| Is the home accessible to the wheelchair? | ☐ Yes | ☐ No |
| Are ramps available in the home setting? | ☐ Yes | ☐ No |
| Describe the client's educational/vocational setting: | | |
| Is the school accessible to the wheelchair? | ☐ Yes | ☐ No |
| Are there 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 therapist: | | |
| Name of school: | | |

| **V. Environmental Assessment** |
|---|
| School therapist's telephone number: |
| Describe how the wheelchair will be transported: |
| Describe where the wheelchair will be stored (home and/or school): |
| Describe other types of equipment which will interface with the wheelchair: |

| **VI. Requested Equipment:** |
|---|
| Describe client's current seating system, including the mobility base and the age of the seating system: |
| Describe why current seating system is not meeting client's needs: |
| Describe the equipment requested: |
| Describe the medical necessity for mobility base and 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: |

| **VII: Signatures of Therapist/Physician and Qualified Rehabilitation Professional (QRP)** | |
|---|---|
| Physician/Therapist's name: | Physician/Therapist's signature: |
| Physician/Therapist's title: | Date: |
| Physician/Therapist's telephone number: (  )  - | |

| Physician/Therapist's employer (name): | Physician/Therapist's address (work or employer address): | |
|---|---|---|
| QRP Name: | NPI: | TPI: |
| QRP Signature: | Date: | |

**VIII. POWER WHEELCHAIRS:**
*Complete if a power wheelchair is being requested*

Describe the medical necessity for power vs. manual wheelchair:
*(Justify any accessories such as power tilt or recline)*

Is client unable to operate a 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 (hand, chin, etc.)?

Has the client been evaluated with the proposed drive controls?

Does the client have any condition that will necessitate possible change in access or drive controls within the next five years?

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

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

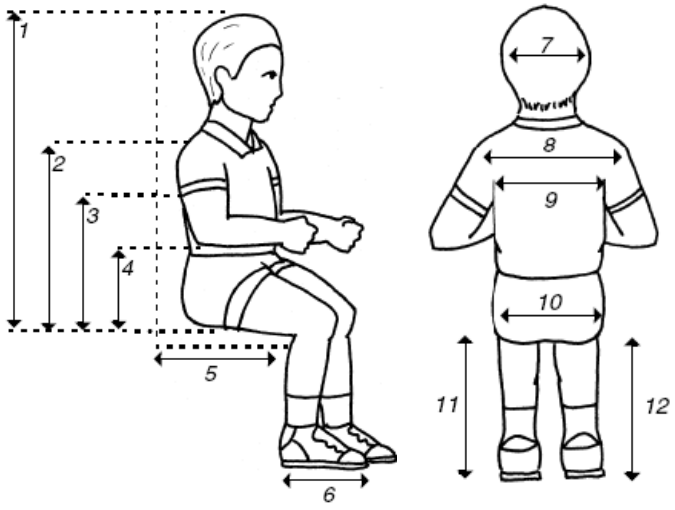
How will training for the power equipment be accomplished?

| IX: Signatures of Therapist/Physician and Qualified Rehabilitation Professional (QRP) | | | |
|---|---|---|---|
| Physician/Therapist's name: | | Physician/Therapist's signature: | |
| Physician/Therapist's title: | | Date: | |
| Physician/Therapist's telephone number: (  )  - | | | |
| Physician/Therapist's employer (name): | Physician/Therapist's address (work or employer address): | | |
| QRP Name: | | NPI: | TPI: |
| QRP Signature: | | Date: | |

# Home Health/CCP Measuring Worksheet

| General Information | |
|---|---|
| Client's name: | Date of birth: |
| Client's Medicaid number: | Height: |
| Date when measured: | Weight: |

**Measurements**




| | |
|---|---|
| 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**

| Signatures of Measurer and Qualified Rehabilitation Professional (QRP) | |
|---|---|
| Measurer's Name | |
| Measurer's Signature: | Date: |
| Measurer's Telephone number: ( ) - | |
| QRP Name: | |
| QRP Signature: | Date: |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