MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices Addendum B: Strollers, Gait Trainers, Standers, Car Seats, and Children's Positioning Chairs

This form must be completed by a physical therapist, occupational therapist, physiatrist, or rehabilitation registered nurse. The Evaluator must complete requested and/or current equipment information, warranty information and economic alternative information.

NOTE: Only complete sections that apply to the requested equipment/accessories. If requesting an equipment/accessories complete Current/None area of the section.

Incomplete information will result in the form being returned to the evaluator for completion.

Beneficiary Name: _____ Mihealth Number: _____

SECTION	☐ Requested	☐ Current ☐ None
Equipment	**Beneficiary's ability to use**	
Stroller	☐ Transport only ☐ Primary mobility device Indicate medical special needs for use and adaptions needed: .	Specify brand, model and serial numbers, age of current device: Length of warranty: _____ Warranty begin date: _____ Where is or will this device be used? *(i.e., home, school, community)*
	☐ Requested	☐ Current ☐ None
Gait trainer *(if less than age 21)*	☐ Is independent with gait trainer. ☐ Requires assistance with mobility using gait trainer. Describe: How many times per day will beneficiary use gait trainer: How far can beneficiary ambulate with gain trainer/device? _____ft. Indicate the expected performance with the requested equipment: Is beneficiary/caregiver compliant with current mobility plan of care? ☐ Yes ☐ No If No, explain:	Specify brand, model and serial numbers, age of current device: Length of warranty: _____ Warranty begin date: _____ Where is or will this device be used? *(i.e., home, school, community)*
	☐ Requested	☐ Current ☐ None
Children's positioning chairs *(if less than age 21) e.g., feeder seat, high/low seat, activity chair, etc.*	☐ Home inaccessible to mobility device. ☐ Beneficiary is > 40 lbs. with limited head and trunk control ☐ Beneficiary has current active seizures ☐ Beneficiary is unable to eat or be safely fed in current mobility device ☐ Crown to hip measurement on Mat evaluation is > 26" If beneficiary is < 40 lbs. or < 26", explain why commercially available products or other mobility devices will not meet the beneficiary's medical/functional needs:	Specify brand, model and serial numbers, age of current device: Length of warranty: _____ Warranty begin date: _____ Where is or will this device be used? *(i.e., home, school, community)*

Beneficiary Name: _____ Mihealth Number: _____

	☐ Requested	☐ Current ☐ None
Equipment	**Beneficiary's ability to use**	**Where device is used**
Car seat	Indicate medical special needs for use and adaptions needed:	Specify brand, model and serial numbers, age of current device: Length of warranty: _____ Warranty begin date: _____ Where is or will this device be used? *(i.e., home, school, community)*

	☐ Requested	☐ Current ☐ None
Stander *(If less than age 21)*	☐ Is dependent with standing ☐ Walks with assistive device ☐ Walks with gait trainer ☐ Required for post-op care Specify treatment plan and state any surgical or other interventions that affect standing:	Specify brand, model and serial numbers, age of current device: Length of warranty: _____ Warranty begin date: _____ Where is or will this device be used? *(i.e., home, school, community)*
	Indicate current standing plan of care (including how many times per day and how long):	
	Is the beneficiary/caregiver compliant with standing plan of care? ☐ YES ☐ NO If NO, explain:	

	☐ Requested	☐ Current ☐ None
Growth adaptability of device	Seat width: _____ Seating system height: _____ Seat depth: _____ Frame adaptablility: _____	Seat width: _____ Seating system height: _____ Seat depth: _____ Frame adaptablility: _____

Equipment	**Device Type** *(attach additional page(s) if necessary)*	**Medical Reason**
All Accessories / Add Ons	☐ Head & Neck Type:	
	☐ Arms Type:	
	☐ Feet Type:	
	☐ Other - Describe	
Medical Reason	Specify Medical Reason for brand(s) and model(s) requested for this beneficiary:	

Beneficiary Name: _____ Mihealth Number: _____

EVALUATOR (PT, OT, PHYSIATRIST OR REHAB RN) ATTESTATION AND SIGNATURE/DATE

I certify that I conducted the evaluation and have completed the information in the appropriate Sections of the MSA-1656-Addendum B and that there is no financial arrangement with the selected durable medical equipment provider and/or the evaluating clinician. I certify that the equipment requested is the most economical alternative that meets the beneficiary's basic medical and functional needs. I certify that the information contained in this form is true, accurate, and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

_____
Evaluation Date

Evaluator Name/Title (Print)

Place of Employment and Address

NPI Phone Number

Evaluator Signature Date

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is voluntary, but is required if payment from applicable.

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