Minnesota Department of **Human Services**

DHS-4075-ENG 8-11

Minnesota Health Care Programs (MHCP)

Stander and Accessories Authorization Form

ASSIGNED NUMBER FROM MN–ITS

Use this form in addition to the MN–ITS Authorization Request transaction or the Authorization Form (DHS-4695) to request authorization for a stander and accessories. Attach the Home Trial Log for Stander (DHS-5538) if required by policy. Fax this form with any additional or required documentation to the medical review agent.

If more space is needed, continue answer on separate sheet and indicate question you are answering.

Provider Information

PROVIDER NAME	NPI/UMPI
CONTACT NAME	PHONE NUMBER ( )

Recipient Information

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	MHCP ID NUMBER

HEIGHT	WEIGHT	OTHER RELEVANT INFORMATION ABOUT SIZE/STATURE

DIAGNOSIS

LIVING ARRANGEMENT

☐ Home alone ☐ Home w/caregiver (who is caregiver _____)

☐ Nursing home ☐ Group home ☐ Assisted Living ☐ ICF/DD

DESCRIBE THE RECIPIENT'S MEDICAL IMPAIRMENTS AND ANY SPECIAL NEEDS

IF ASSISTANCE IS NEEDED BY THE RECIPIENT FOR ANY ADLS, LIST AND DESCRIBE THEIR ABILITY AND HOW MUCH ASSISTANCE THEY NEED

RECIPIENT HAS PCA SERVICES	NUMBER OF HOURS PER DAY
☐ Yes ☐ No	

DESCRIBE PCA RESPONSIBILITIES

GIVE A COMPLETE DESCRIPTION OF THE RECIPIENT'S FUNCTIONAL IMPAIRMENTS (transfers, ambulation, range of motion). DESCRIBE HOW MUCH ASSISTANCE IS NEEDED.

Stander requested

HCPCS CODE	MAKE	MODEL
WEIGHT CAPACITY	HEIGHT RANGE	
	FROM	TO

DESCRIBE THE MEDICAL NECESSITY FOR THE REQUESTED STANDER AND LIST ALL OTHER ACCESSORIES REQUESTED AND THE MEDICAL NECESSITY UNIQUE TO THIS RECIPIENT

Description	**Medical Necessity**

List all less costly standing alternatives tried and explain why that equipment will not meet the recipient's medical needs. (i.e. other standers, gait trainers, immobilizers, KAFOs, other braces, etc.) Explain what less costly standers were tried and why they were ruled out.

Describe recipient's current standing program. Include how long they stand, all current goals, baseline status/measurements, progress toward functional goals and benefits of standing that are specific to this recipient.

Describe where the stander will be used, and the approximate duration at each location (hrs/day and days/wk). Describe which daily activities would require the use of a stander that could not be done in any other position.

LIST ANY ENVIRONMENTAL FACTORS TO CONSIDER WHEN DECIDING ON THIS SPECIFIC MODEL OF STANDER

DESCRIBE THE RECIPIENT'S ABILITY TO OPERATE THE STANDER INDEPENDENTLY. IF NOT, LIST WHO WILL ASSIST AND HOW.

Describe the trial period when the recipient used this or similar equipment. Include the length of each session, number of days in the trial, and specific medical and or functional benefits resulting from the trial. Explain the environment of the trial. Attach a copy of the standing trial log.
Describe any relative impairments (range of motion, bowel/bladder/intestinal function, history of fractures or risk for bone density issues, respiratory status) that have proven to be positively changed for this recipient by passive standing.
List existing equipment, age of equipment, make, and model. If recipient has an existing stander, describe why it is no longer meeting the recipient's medical needs. If current stander is being replaced due to extensive repairs, give estimates on repairs needed.
EXPLAIN WHETHER THE REQUESTED STANDER HAS ENOUGH ADJUSTMENT TO ALLOW FOR MODIFICATION DUE TO RECIPIENT GROWTH AND OR SIZE CHANGES
Describe recipient's roles and responsibilities; in the community, at work, and at home, and how the standing program is expected to affect the recipient's life.
APPROXIMATE LENGTH OF TIME NEEDED (PURCHASE OR RENTAL)
INDICATE NEED TO RENT A STANDER TO FULFILL THE REQUIREMENT OF A TRIAL PERIOD BECAUSE A MANUFACTURER'S DEMO IS NOT AVAILABLE
ANY ADDITIONAL INFORMATION THAT WOULD BE USEFUL IN EVALUATING THIS REQUEST

SIGNATURE OF EQUIPMENT SPECIALIST	DATE
SIGNATURE OF PT/OT/OTHER PROFESSIONAL INVOLVED IN EVALUATION AND CREDENTIALS EVALUATION REQUIRED FOR STANDER AUTHORIZATIONS	DATE
SIGNATURE OF PHYSICIAN VERIFYING INFORMATION	DATE