Clear Form

Minnesota Department of **Human Services**

DHS-6008-ENG 7-11

Minnesota Health Care Programs (MHCP)

Bath/Shower/Toileting Equipment 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 enclosed medical beds. 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

DIAGNOSIS CODE	DESCRIPTION

HEIGHT	WEIGHT	OTHER RELEVANT INFORMATION ABOUT SIZE/STATURE

DESCRIBE RECIPIENT'S MEDICAL CONDITION AND THE MEDICAL NECESSITY FOR THE REQUESTED EQUIPMENT

LIVING ARRANGEMENT

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

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

ADL ASSISTANCE

☐ Totally dependant ☐ Partially dependant ☐ Independent

DESCRIBE RECIPIENT'S NEED FOR ASSISTANCE FOR ACTIVITIES OF DAILY LIVING

INDICATE HOW THE RECIPIENT TRANSFERS

☐ Independent ☐ Pivot transfer SBA/CGA ☐ Sliding board ☐ Moderate assistance

☐ Maximum assistance ☐ 1 ☐ 2 ☐ Lift device (indicate lifting device utilized with this recipient):

_____

Recipient has PCA services.	☐ Yes	☐ No	Number of hours/days: _____
Recipient is alone.	☐ Yes	☐ No	Number of hours/days: _____

DESCRIBE PCA RESPONSIBILITIES

List recipient's current equipment, age of equipment, make and model. Describe reason(s) this equipment no longer meets recipient's medical needs. If current equipment is being replaced due to extensive repairs, give estimates of repairs needed.
(If recipient is bed bathing or using lift equipment to bathe, indicate reason this is no longer meeting recipient's needs.)

LIST OTHER EQUIPMENT USED BY THE RECIPIENT (hospital bed, patient lift, wheelchair, etc.)

Bath/shower/toileting equipment requested	MAKE	MODEL

EXPLAIN WHERE BATH/SHOWER/TOILETING EQUIPMENT WILL BE USED. INDICATE APPROXIMATE DURATION OF USE PER DAY.

Document results of an in-home assessment. Include evidence that equipment fits in all appropriate areas of recipient's home, results of transfer trial practice with caregivers using the equipment, and assessment results noting that the equipment will meet the recipient's needs. (Note where the bath equipment will be stored to assure recipient's exclusive use of the bath equipment and so that others may access the bath/toilet areas, if needed)

List all less costly alternatives and explain the reason(s) bath equipment make and model will not meet the recipient's medical needs. Provide make and model of alternative equipment considered and rejected, cost comparison and thorough documentation of the reasons less costly alternatives, including bed bath, will not meet the recipient's needs.

EXPLAIN WHETHER THE EQUIPMENT ALLOWS RECIPIENT TO INDEPENDENTLY BATHE, SHOWER, OR TOILET HIM/HERSELF

List all requested accessories and the medical necessity for each. If requesting tilt/recline, include documentation providing reason(s) this is necessary, given the expected daily use time.

Description	**Medical Necessity**

Include the manufacturer's quote, price list or invoice with the request for authorization. Do not modify, alter or change the pricing documentation. Do not block out any information on the pricing documentation.

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