Utah Department of
Health & Human Services
Integrated Healthcare

Power Wheelchair Training Checklist

Member's Name: _____ Medicaid ID #: _____

Initial Evaluation Date: _____ Final Evaluation Date: _____

	DEMONSTRATED TASK	Initial Evaluation (initial applicable boxes)		Final Evaluation (initial applicable boxes)	
	(if not applicable indicate with N/A)	**Yes**	**No**	**Yes**	**No**
1	Demonstrates awareness of control unit?				
2	Able to tolerate movement?				
3	Able to release control unit to stop when given a command?				
4	Able to move chair in any direction in an open area?				
5	Tolerates hand-over-hand assistance from others?				
6	Demonstrates the ability to follow requests to go forward, left, right or stop?				
7	Demonstrates the ability to drive wheelchair in an uncrowded hallway?				
8	Knows when to use horn appropriately to warn others of presence?				
9*	Demonstrates the ability to drive wheelchair with supervision?				
10	Demonstrates the ability to drive wheelchair between two people?				
11	Demonstrates the ability to maneuver around two people?				
12	Demonstrates the awareness of other people in their pathway and stops chair to prevent hitting others?				
13	Demonstrates the ability to drive through doorways?				
14	Demonstrates the ability to drive up and down ramps?				
15	Demonstrates the ability to maneuver around large obstacles?				
16**	Begins to recognize changes in surfaces and stops?				
17**	Begins to maneuver wheelchair outside with supervision?				
18**	Begins to learn the concept of backing up with cuing when the area is free of obstacles?				
19	Demonstrates awareness of space behind and demonstrates appropriate precautions when backing up?				
20*	Demonstrates the ability to turn on and off the wheelchair with indirect supervision?				
21*	Demonstrates the ability to maneuver through crowded hallways with indirect supervision?				
22*	Demonstrates the ability to freely maneuver wheelchair with indirect supervision?				
23*	Demonstrates the ability to access child-specific environments with indirect supervision?				

For the Final Evaluation: * the phrase "indirect supervision" becomes "no supervision" ** Question becomes "Can"

Therapist name that observed ***initial*** training evaluation:

Print Name:_____

Therapist Signature: _____

Date: _____

Therapist name that observed ***final*** training evaluation:

Print Name:_____

Therapist Signature: _____

Date: _____

After completion of initial evaluation section, include this form with the prior authorization request.

Updated October 2019