State of Illinois
Department of Healthcare and Family Services

MOTORIZED WHEELCHAIR EVALUATION FORM

Resident Name

Recipient Identification Number (RIN)

Nursing Facility Name

	Yes	No
1. Does person have a physical limitation that prevents him or her from accomplishing a mobility-related activity of daily living?	☐	☐
If no, stop here. If yes, go to Question 2.		
2. Is the person unable to perform any of the following activities:		
A. Walk or propel a manual wheelchair unassisted to the bathroom?	☐	☐
B. Walk or propel a manual wheelchair unassisted to the dining room?	☐	☐
C. Leave the nursing home unassisted to go to a movie?	☐	☐
D. Walk or propel a manual wheelchair unassisted in less than one minute?	☐	☐
If no, stop here. If yes, go to Question 3.		
3a. Does the person have the mental capacity sufficient for safe performance of mobility-related functions with the use of a motorized wheelchair?	☐	☐
3b. Could the person be trained for safe operation of a motorized wheelchair?	☐	☐
If the answer to both Questions 3a & 3b is no, stop here. If yes, go to Question 4		
4. Does the person have the physical capabilities for the safe performance of a motorized wheelchair?	☐	☐
If no, stop here. If yes, go to Question 5.		
5. Would the person consent to a full evaluation for a motorized wheelchair?	☐	☐

Name of person completing form: _____

Title/Position: _____

Declaration

Under penalty of perjury, I certify and declare that I evaluated the nursing facility resident named above and that the evaluation information contained in this form is, to the best of my knowledge and belief, true and correct.

Signature of person completing form: _____ Date: _____