Sample: Letter of Necessity for Mount’n Mover Mounting System

Re: **[Client’s Name]**

DOB: __/__/__

To whom it may concern:

[Name] was seen at [home/clinic]. He was referred for an [Occupational/Physical] Therapy evaluation for a new Mount for his/her [communication device/tray].

[Name] is a ___ year old male/female with a diagnosis of _________. [Name] is approximately [height] and [weight]. Current equipment used includes a power wheelchair with tilt, bilateral AFO’s, roll in shower chair, hospital bed, overhead lift system, van lift and [communication device] and [Brand] Mount. [Name] currently attends [program]. He/she is toilet trained and uses the toilet independently.

[Name] accurately drives a [Make/model] power chair with joystick control. The chair was delivered [date] by [Dealer]. He/she has a long history of driving power chairs.

[Name] is friendly and cooperative throughout the evaluation, often expressing his/her opinion and answering questions with his/her communication device. He/she accurately uses his/her right hand to access [number] locations on his/her communication device. He/she has been using the requested mounting system for a 3 week trial. This mounting system provides independence through positioning and ease of use. It allows for appropriate communication device position while the chair is tilted. [Name] is able to move his/her device or tray to where he/she needs them to be when needed and at the angle needed. This avoids caregiver guessing and frustration and provides [name] continuous access to their communication device in the event of an emergency. [Name] currently uses a [Brand] mount that must be put on and taken off by his/her caretakers throughout the day and does not adjust for tilt in his/her power chair, this decreases his/her independence and ability to move the mount and communicate at all times. This allows for independent transfers [to the toilet, bed, chair, and floor] as needed.

At this time it is recommended that [name] obtain a Mount’n Mover for his/her communication devices. Options required include:

- [List items as needed]
- Dual Arm M2TQ-H
  It is required due to (name) limited reach. It extends across midline as well as inward and forward for optimal positioning. Requires High Torque/Resistance as his/her communication device weighs more than 5 lbs

- 18” Square Post P18
  Is required for appropriate height of the device for mounting on his/her wheelchair

- WB2 and WC-AAP
  Wheelchair Bracket and Angle Adjustment Plate required to attach mounting post to wheelchair

- 12 x 16 Tray with Lip with Quick Release Plate TR-12x16-Q
  Required for eating and fine motor activities to increase his quality of life and independence

- Device Plate (specific to device)
  Required to attach (device) to mounting plate

- iTab Tray with Quick Release Plate TR-iTab-Q
  Required for access to additional technology apps. Increasing his/her independence and quality of life. This position further works on shoulder stability

- Wheelchair Adapter Plate WC-APA4
  Required for (wheelchair e.g. Permobil) attachment

- Wheelchair L Angled Extension Plate WC-LAE
  Required to avoid his/her attached cup holder, brakes, and footrests

- Shipping and Handling

- Installation

Thank you for your consideration of this medically necessary equipment.

Signature

[Name and Title]