DDD-1345A FORFF (5-19)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

MEDICAL JUSTIFICATION FOR HOME MODIFICATIONS

Date:

Phone No.: ______________________

Fax No.: ______________________

Dear Dr.

Your patient, referenced below, is enrolled in the Arizona Long Term Care System (ALTCS) program through the Department of Economic Security's Division of Developmental Disabilities (DES/DDD). The Planning Team recommends the following:

Ramp	Bathroom flooring removal/replacement	Bedroom flooring removal/replacement
Platform lift	Bidet toilet seat	Hand-held shower wand
Adaptive stairs	Modify sink/vanity in bathroom	Modify/widen doorway in bedroom
Threshold modification	Modify/widen doorway in bathroom	Hand rails
Turn landing	High-rise, elongated toilet/Toilet adaptation	Grab bars
	Modify shower	

Other (explain): ____

ALTCS requires a written order from the Primary Care Provider (PCP) so we can provide the recommended home modifications. This order must include the required home modifications as well as the patient's diagnosis listed below and becomes part of the member's record.

Patient's Name: ______________________ Date of Birth: ____________ AHCCCS ID No.: ____________

Mark all diagnoses that apply:

Cerebral Palsy   Autism   Cognitive/Intellectual Disability   Epilepsy   At Risk

Additional diagnoses (must describe physical limitations): ______________________________

Dependent on mobility assistive equipment:

Wheelchair   Walker   Cane   AFO's   Other (must list): ______________________

TO BE COMPLETED BY THE PRIMARY CARE PROVIDER

Your review and response is urgently needed. If you agree that the above recommendations are medically necessary, please sign and return this document within 5 business days to the contact information noted below. Without your timely response, the ALTCS member will be denied the home modification services listed above. The Division will fund these modifications with Medicaid dollars.

Primary Care Provider's (PCP) Signature: ______________________________ Date: ____________

Thank you for your attention to this matter.

Respectfully,

Certified Environmental Access Consultant (C.E.A.C.)
DDD Environmental Modifications Specialist

FAX TO: DIVISION OF DEVELOPMENTAL DISABILITIES
Health Care Services

ATTN: ______________________

Fax No.: ______________________

Phone No.: ______________________

Equal Opportunity Employer / Program • Auxiliary aids and services are available upon request to individuals with disabilities • To request this document in alternative format or for further information about this policy, contact the Division of Developmental Disabilities ADA Coordinator at 602-542-0419; TTY/TDD Services: 7-1-1