

HOME MODIFICATIONS SERVICE REFERRAL AND REQUEST**SECTION A: MEMBER INFORMATION – COMPLETED BY SUPPORT COORDINATOR**

On, _____, the Planning Team met and identified a potential need for a home modification. The Team understands that a home modification assessment will be scheduled within 30 calendar days of that date.

NAME (*Last, First, M.I.*) _____ DATE OF BIRTH _____

PHYSICAL ADDRESS (*No., Street*) _____

CITY _____ STATE _____ ZIP CODE _____

AHCCCS ID NUMBER _____ ASSISTS ID NUMBER _____

CONTACT PERSON'S NAME _____

PHONE NUMBER _____ PREFERRED LANGUAGE _____

LIVES INDEPENDENTLY? Yes No RESIDENCE (*Check one*): Member/family Owns Rents

NAME OF PRIMARY CARE PHYSICIAN (PCP) _____

PHONE NUMBER _____ FAX NUMBER _____

DDD QUALIFYING DIAGNOSIS (*And any others that may contribute to physical limitations*)

Cerebral Palsy Epilepsy Cognitive/Intellectual Disability Autism

Additional Diagnosis (*must describe physical limitations*): _____

MOBILITY CONCERNS

WALK:	Does not walk	Independently	1 to 5 feet	6 to 10 feet	More than 10 feet
MARCH IN PLACE:		Independently	Holding on to an object/another person		
WALK UP OR DOWN STAIRS:		Independently	Holding on to a rail/wall/person	N/A	
TRANSFERS TO AND FROM:	Bed/Chair	Chair/Commode	Walker	With physical assistance of another person	
BALANCE:	Stand with feet at shoulder length:	Independent	Holding on to an object		
	Stand on one foot:	Independent	Holding on to an object		

Review DME vs. Home Modification Referral Matrix:

Refer Member/Responsible Person to Member's Primary Care Physician Submit Referral to Home Mod Unit

MOBILITY DEVICES USED BY THE MEMBER

WALKS WITH ASSISTANCE:	Walker	Cane	Crutches	Physical assistance of another person
WHEELCHAIR:	Manual	Motorized	Scooter	Stroller
LIFT SYSTEM:	Floor Model (e.g. hooyer)		Ceiling Lift	

SUPPORT COORDINATOR'S NAME (*Print*) _____ PHONE NUMBER _____

SUPPORT COORDINATOR'S SIGNATURE _____ DATE _____

SECTION B: COMPLETED BY THE HOME MODIFICATION UNIT

DATE RECEIVED _____ 30 DAYS _____ DATE/TIME SCHEDULED _____

PROJECT NUMBER _____ SERVICE PLAN AGREEMENT: Yes No

DATE ASSESSMENT COMPLETED _____

(*Refer to Home Modifications Service Assessment Form DD-1678A for assessment recommendations and outcomes.*)

SECTION C: HEALTH CARE SERVICES REVIEW OF MEDICAL NECESSITY COMPLETED BY THE MEDICAL DIRECTOR/DESIGNEE

Approve Deny DME Referral

MEDICAL DIRECTOR'S/DESIGNEE'S NAME (*Print*) _____

MEDICAL DIRECTOR'S/DESIGNEE'S SIGNATURE _____ DATE _____

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