DD-211-FF (9-17)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

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. hoyer) ☐ 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 _____