DDD-1345A FORFF (5-23)

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
- ☐ Platform lift
- ☐ Adaptive stairs
- ☐ Modify Threshold
- ☐ Turn landing
- ☐ Auto-door opener
- ☐ Modify shower
- ☐ Hand-held shower wand
- ☐ Grab bars
- ☐ Other (explain below):
- ☐ Standard toilet
- ☐ High-rise, elongated
- ☐ Bidet toilet seat
- ☐ Toilet adaptation
- ☐ Wall mount roll-under bathroom sink
- ☐ Modify bathroom sink/vanity
- ☐ Modify/widen bathroom door
- ☐ Modify bathroom closet
- ☐ Modify/relocate bathroom wall
- ☐ Bathroom flooring removal/replacement
- ☐ Bedroom flooring removal/replacement
- ☐ Modify/widen bedroom door
- ☐ Modify hall bedroom closet
- ☐ Modify/relocate hall bedroom walls
- ☐ Modify master bedroom closet
- ☐ Modify/relocate master bedroom walls
- ☐ Modify hall closet
- ☐ Handrails

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 ☐ Down Syndrome ☐ At Risk

☐ Additional diagnoses (must describe physical limitations): _____

Dependent on mobility assistive equipment:

☐ Wheelchair ☐ Stroller ☐ Scooter ☐ Walker ☐ Gait Trainer ☐ Cane ☐ Crutches ☐ AFO's

☐ Transfer/Lift System ☐ Other (must list): _____

TO BE COMPLETED BY THE PRIMARY CARE PROVIDER

Your review and response is urgently needed. Please sign and return within 3 business days to the contact information noted below if you agree that the above recommendations are medically necessary. 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.: _____