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, Gate Code)*: ______________________

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 Down Syndrome Autism At-Risk

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

Before submitting the DD-211, review DME vs. Home Modification Referral Matrix:
Referral to Home Mod Unit not required when DME can meet needs. Refer Member/Responsible Person to Member's Primary Care Physician. Submit Referral to Home Mod Unit ***only*** when DME cannot meet member's needs.

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 N/A
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 N/A
Stand on one foot: Independent Holding on to an object N/A

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: ____________

SC Supervisor's Name *(Print)*: ______________________ Phone Number: ____________

SECTION B: COMPLETED BY THE HOME MODIFICATION UNIT

Date Received: ____________ 30 Days: ____________ Date/Time Scheduled: ____________

Project Number: ______________________ Service Plan Agreement: Yes No

Assessment Completed by Name *(Print)*: ______________________ Date Completed: ____________

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

SECTION C: REVIEW 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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