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| **SECTION A. TO BE COMPLETED BY REQUESTOR. ATTACH ALL REQUIRED DOCUMENTATION.** | | |
| **Fax completed form to:** AHCCCS/DFSM/Tribal ALTCS  Fax: (602) 254-2426  **Documents Attached:**  Service Assessment  Uniform Assessment Tool (UAT)  Map of Physical Address for Rural Areas | **Tribal ALTCS Program** |  |
| **Case Manager Name** |  |
| **Tribal ALTCS Program Address** |  |
| **Phone/Fax Number** |  |
| Signatures acknowledge that both Tribal ALTCS Case Manager and Supervisor have reviewed and submitted the necessary documentation to proceed with home modification request.  Note: If all necessary documents are not included in the request the request/packet cannot be processed. | **Signature** |  |
| **Case Manager** |  |
| **Supervisor** |  |

|  |  |  |
| --- | --- | --- |
| 1. | **Member’s Name** |  |
|  | **DOB** |  |
|  | **AHCCCS ID #** |  |

|  |  |  |
| --- | --- | --- |
| 2. | *(Where the home modification will occur)* | |
|  | **Member’s Residential Address** |  |
|  | **City & Zip Code** |  |
|  | **Phone #** |  |
|  | **Alternative Phone #** |  |

|  |  |  |
| --- | --- | --- |
| 3. | *(If different from the above residential address)* | |
|  | **Member’s Mailing Address** |  |
|  | **City & Zip Code** |  |
|  | **Phone #** |  |
|  | **Alternative Phone #** |  |

(Attach a map for all rural areas.)

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| 4. | *(Primary Care Provider’s Information)* | |
|  | **PCP Name** |  |
|  | **Phone #** |  |
|  | **Fax #** |  |
|  | **Diagnosis & Code (related to need)** |  |

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| 5. | *(Member Resides in – check one)* | |
|  |  | **Own Home** |
|  |  | **Rent** |
|  |  | **Other: *(****specify****)*** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 6. | **Current Activities of Daily Living Status** | Independent | Mod Assist | Dependent |
|  | **Bladder/Bowel Status** | Continent | Mod Incontinent | Total Incontinent |
|  | **Mental Status** | Alert | Confused |  |

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| --- | --- | --- | --- | --- |
| 7. | **Current Mobility Status** | Independent | Walker/Cane | Wheelchair |

8. Describe modification(s) being requested (use separate sheet of paper if needed):

|  |  |  |  |
| --- | --- | --- | --- |
| **MODIFICATION REQUESTED** | **JUSTIFICATION** | **APPROVED** | **DENIED** |
| Ramp with Handrails and Landing |  |  |  |
| Walk-in Shower and Hand-Held Shower  Head |  |  |  |
| Roll-in Shower and Hand-Held Shower  Head |  |  |  |
| Grab Bars –  Shower or  Toilet |  |  |  |
| Widen Doors-  Bathroom  Bedroom  Front |  |  |  |
| Lever Handles-  Bathroom  Bedroom  Front Door |  |  |  |
| High Rise Toilet or  Roll Under Sink |  |  |  |
| Special Request- Please Explain |  |  |  |

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| **Physician’s Signature** | **Date** |

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| **SECTION B. TO BE COMPLETED BY AHCCCS/DFSM/Tribal ALTCS** | | | |
| **Residential or Commercial Contractor/Provider Name** | **License #** | **Provider ID** | **Cost** |
|  |  |  | $ |
| **Comments:** | | | |
| **Approved** |  |  |  |
| **Signature** | **(Name and Title)** | **Date** |
| **Denied** |  |  |  |
| **Signature** | **(AHCCCS Medical Director or Designee)** | **Date** |