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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** |  |

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

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

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| 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****)***  |

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| 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):

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| --- | --- | --- | --- |
| **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** |