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.)

4. *(Primary Care Provider's Information)*
   PCP NAME _____
   PHONE # _____
   FAX # _____
   DIAGNOSIS & CODE (RELATED TO NEED) _____

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

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			

PHYSICIAN'S SIGNATURE **DATE**

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