**Pursuant to Chapter 44 of the Department of Health’s Medicaid Rules**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Participant Name:** |  | **Age:** |  | **Submission Date:** |  |

**Diagnosis and Medical Condition:**

**S-5165 NU Environmental Modification (New)  S-5165 Environmental Modification (Repair)**

**Environmental modification request shall be functionally necessary and shall:**

|  |  |  |
| --- | --- | --- |
| 1. Contribute to a person’s ability to remain in or return to their home and out of   an institution | Yes | No |
| 1. Be necessary to ensure the person’s health, welfare and safety | Yes | No |

**Description of the environmental concern or need:**

**Based upon the assessment from an occupational or physical therapist, a description of how the environmental concern is related to the participant’s diagnosed disability:**

**Explanation of how addressing the environmental concern will: 1) Contribute to the participant’s ability to remain in, or return to, their home; 2) Increase the participant’s independence; 3) Address the participant’s accessibility concerns; and 4) Address health and safety needs of the participant.**

**Attach two quotes:**

|  |  |  |
| --- | --- | --- |
| * Detailed description of the work to be completed, including drawing or pictures, when appropriate | Yes | No |
| * An itemized estimate of the material and labor needed to complete the job, including costs for clean up | Yes | No |
| * An estimate for the building permit, if needed | Yes | No |
| * An estimated timeline for completing the job. | Yes | No |
| * Name, address, and telephone number of the provider | Yes | No |
| * Signature of the provider | Yes | No |

**Attach additional documentation:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * Documentation that waiver is payer of last resort | | | Yes | No |
| * Proof of ownership of the residence, if applicable | | | Yes | No |
| * Written approval from the homeowner or landlord, if applicable | | | Yes | No |
| * Signed assessment from the occupational or physical therapist | | | Yes | No |
| * List of previous home modifications purchased through the waiver | | | Yes | No |
| Year Approved | Total Amount | Description of Modification |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Additional Information:**

**Professional making the recommendation/date:**