Environmental Modification Request Worksheet

HOME AND COMMUNITY-BASED SERVICES

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
2. 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:_____