ACCESSIBILITY SURVEY

-- This form must be used for in-home assessments and assessments must take place in the member's home –

-- This form is not required if the patient resides in a Skilled Nursing or Intermediate Care Facility –

1. Individual's name:	Medicaid ID:	2. Date of Survey:	3. Equipment requested:

4. Address of Accessibility Survey	
Street Address:	City, State, Zip Code:

5. What type of home does the person live in?		6. What type of facility is this home?	
☐	Single-story home	☐	Private home
☐	Multi-story home	☐	Boarding home
☐	Apartment	☐	Group home
☐	Mobile home	☐	Other:

7. How many levels or floors are there in this home?	
8. What is the width of the narrowest doorway in the home that the Wheeled Mobility Device would need to pass through?	

9. Describe any caretaker's physical limitations, which affect the individual's care.

When using the indicated equipment in question #3:	Yes	No	Type of surface: e.g. carpet, tile	Measurement
10. Is at least one entrance to the home accessible?	☐	☐		
11. Is there a ramp or other device used to enter the home?	☐	☐		
12. Is at least one bathroom in the home accessible?	☐	☐		
13. Is at least one bedroom accessible?	☐	☐		
14. Is the kitchen accessible?	☐	☐		
15. Is the living room accessible?	☐	☐		
16. Are the hallways accessible?	☐	☐		

What are the home accessibility barriers (thresholds, steps, level changes, room size/shape, tight turns, narrow doorways, hallways):

	Location	Description of Barrier
17. Barrier #1:		
18. Barrier #2:		

19. Describe alternate accommodations that are used to bridge accessibility barriers (ramps, structural modification, bedside commode):

20. List other customary or anticipated customary environments and associated functional tasks intended for this equipment request:

By signing below, the ATP or agency designee attests that given the person's specific medical and functional needs, predicted equipment measurements (width, length, height, turning radius) and projected environmental demands (terrain, functional tasks); the requested Wheeled Mobility Device will be appropriate within the home and other current or anticipated customary environment(s), as trialed.

21. Signature:	22. Agency Affiliation:

I reviewed the Wheeled Mobility request by the evaluating team. I confirm that an onsite in-home assessment with the DME Provider was completed for the requested equipment and agree with these recommendations which address my medical needs and typical daily tasks. I understand that my insurance benefit will be used to pay for the Wheeled Mobility Device.

23. Signature:	24. Relationship to Person (if not recipient):	25. Date: