ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS (HOME MODIFICATIONS) REFERRAL FORM

Environmental Accessibility Adaptations (EAAs, also known as Home Modifications) are physical home modifications that are necessary to ensure the health, welfare, and safety of the individual or enable the individual to function with greater independence in the home, without which the member would require institutionalization. The services are available in a home that is owned, rented, leased or occupied by the member. For more information, review the Environmental Accessibility Adaptation (Home Modifications) Authorization Guide.

Complete and submit this referral form with the *Outpatient Medicaid – Prior Authorization Fax Form* either online (recommended) at **www. CAHealthWellness.com** or by **fax at 866-724-5057**.

☐ **Initial request** ☐ **Extension request** ☐ **Member consented to home modification referral**
Type of Request (check all that apply)
☐ **Equipment** ☐ **Home modification** ☐ **Personal emergency response system (PERS)**
Eligibility Criteria
☐ Yes ☐ No Member at risk for institutionalization in a nursing facility.
Member Information

Member name:		**Date of birth (DOB)**:
Medi-Cal ID:	**Phone number:**	**Preferred language:**
Home address:		
Contact name: **(if different than member)**		**Relationship:**
Phone number:		**Preferred language:**
Member height:		**Member weight:**
Member's diagnosis (*related to home modification need*):		
Member's need for home modification:		

Community Supports Provider Information (Servicing Organization)	
Organization name:	
Tax identification (ID):	**National Provider Identifier (NPI):**
Staff name:	**Title:**
Phone number:	**Fax number**:

Required Documents (upload documents with the referral form)

- **Provider Order** – licensed health care provider's *(medical doctor, physician assistant or nurse practitioner)* order specifying the requested equipment or service as well as documentation from the provider of the equipment or service describing how the equipment or service meets the medical needs of the member, including any supporting documentation describing the efficacy of the equipment where appropriate.
- **Physical or occupational therapy evaluation and report** – evaluate the medical necessity of the requested equipment or service.
  Date of physical or occupational therapy evaluation and report: _____
- **Bids or cost estimates** – for the requested service, including itemized list of services, cost, labor, and applicable warranties. If possible, a minimum of two bids from appropriate providers.
  Total cost of bid #1: $_____ If applicable, total cost of bid #2: $_____
- **A home visit** – conducted to determine the suitability of requested equipment or service.
  Date of home visit: _____or Date of scheduled home visit:_____