**DEPARTMENT OF HEALTH SERVICES** **STATE OF WISCONSIN**

Division of Medicaid Services Wis. Admin. Code § DHS 107.02(3)

F-02891 (08/2022)

**FORWARDHEALTH**

**DURABLE MEDICAL EQUIPMENT HOME ACCESSIBILITY REPORT**

**INSTRUCTIONS:** Type or print clearly.

Providers are required to have a Durable Medical Equipment Home Accessibility Report form completed by a durable medical equipment (DME) professional before submitting a prior authorization request on the Portal, by fax, or by mail, if applicable. The form may be completed in person or through video conferencing. Providers may call Provider Services at 800‑947‑9627 with questions.

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| **SECTION I – MEMBER INFORMATION** | | |
| 1. Name – Member (Last, First, Middle Initial) | | |
| 2. Member ID Number | 3. Date of Birth – Member | |
| 4. Address Evaluated (Street, City, State, Zip+4 Code) | | |
| 5. Describe the DME being requested. | | |
| 6. What setting will the DME be used in? Check all that apply.  Assisted living facility  Community  Home  School  Skilled nursing facility | | |
| **SECTION II – HOME INFORMATION** | | |
| 7. Type of Home:  Apartment  Mobile home  Multi-story home  Single-story home | | |
| 8. Is an Americans with Disabilities Act (ADA)-compliant ramp present?  Yes  No  If yes, indicate the rise, run, and location of the ramp in the spaces provided below.  Rise (in inches):  Run (in inches):  Location:  If no, describe how the member will be transferred into and out of the home. | | |
| **SECTION III – CAREGIVER INFORMATION** | | |
| 9. Does the member live with a caregiver?  Yes  No | | |
| 10. Does the caregiver have limitations? If yes, describe the limitations in the  space below.  Yes  No | | |
| 11. Does the member spend time at home alone?  Yes  No  If yes, indicate how many hours per day the member spends home alone.        hours per day | | |
| 12. Does the member receive home health services or personal care services?  Yes  No  If yes, indicate the number of hours per day the member receives those services.        hours per day | | |
| 13. Does the requested DME reduce the burden of care to the caregivers,  home health aides, or personal care workers?  Yes  No  If yes, describe how the DME will reduce the burden of care. | | |
| **SECTION IV – HOME SURVEY** | | |
| 14. Check the appropriate box to indicate whether the following areas of the home are fully accessible for the member with the requested DME.  Entrance  Yes  No  Not Applicable  Bedroom  Yes  No  Not Applicable  Bathroom  Yes  No  Not Applicable  Kitchen  Yes  No  Not Applicable  Garage  Yes  No  Not Applicable  Hallways  Yes  No  Not Applicable  If “No” is checked for any area, specify which area is not fully accessible and what the barriers to access are. | | |
| 15. What is the primary mode of transportation for the member?  Facility vehicle  Medical transport  Member-owned vehicle  Make and Model  Does the member or caregiver report the vehicle is in  good working condition?  Yes  No  Has the vehicle been modified for the member’s use?  Yes  No  School bus  City bus  Other: | | |
| 16. Does the requested device fit in the primary mode of transportation?  Yes  No  Not Applicable | | |
| 17. Is the member or caregiver willing and able to transport the device?  Yes  No  Not Applicable | | |
| 18. How will the member be transported?  Typical car seat  Adapted car seat  Commercial car seat  In the requested device  Other | | |
| 19. If the member will primarily use medical transport, how will the member access other normal life activities in the community? | | |
| 20. If the member and the device will be transported differently, explain. | | |
| **SECTION V – SAFETY OPERATION** | | |
| 21. Indicate whether the member can fully and independently operate the DME:  Inside the home  Yes  No  Not Applicable  Outside the home  Yes  No  Not Applicable | | |
| 22. Indicate whether the caregiver is willing and able to operate the device:  Inside the home  Yes  No  Not Applicable  Outside the home  Yes  No  Not Applicable | | |
| **SECTION VI – AUTHORIZED SIGNATURE** | | |
| I attest under penalty of law that the information provided above is truthful and accurate to the best of my knowledge. All responses are legally binding and will be used in the service authorization adjudication process. | | |
| 23. Name – Evaluator (printed) | | 24. Title – Evaluator |
| 25. **SIGNATURE** –Evaluator | | 26. Date of Survey |