

MOBILITY HOME ASSESSMENT EVALUATION FORM

PATIENT INFORMATION

NAME: _____

ADDRESS: _____

PHONE: _____ DATE OF BIRTH: _____

PATIENT REQUESTED TYPE OF MOBILITY ASSISTIVE EQUIPMENT (MAE)

MANUAL WHEELCHAIR POV/SCOOTER POWER WHEELCHAIR

TYPE OF HOME

SINGLE HOME MULTI-STORY APT./CONDO MOBILE HOME

HANDICAP ACCESSIBLE? (RAMPS, STAIRS, ELEVATOR) INTERIOR: NO YES EXTERIOR: NO YES

COMMENTS:

HOME ENVIRONMENT

*ARE THERE ANY FACTORS SUCH AS TEMPERATURE, PHYSICAL LAYOUT, SURFACES, OR OBSTACLES THAT WILL RENDER THE MAE UNUSABLE IN THE BENEFICIARY'S HOME?

HAS THE ABOVE-PRESCRIBED EQUIPMENT BEEN DEMONSTRATED TO ENSURE USABILITY IN THE FOLLOWING LOCATIONS:

BATHROOM YES NO COMMENTS: _____
 BEDROOM YES NO COMMENTS: _____
 KITCHEN YES NO COMMENTS: _____
 HALLWAYS YES NO COMMENTS: _____
 OTHER ROOMS YES NO COMMENTS: _____

SUPPLIER ATTESTATION

I HAVE COMPLETED A PRELIMINARY ASSESSMENT OF THE PATIENTS HOME AND CONCLUDE THAT, BASED UPON THE ABOVE INFORMATION, THE MOST APPROPRIATE TYPE OF POWER MOBILITY DEVICE FOR THIS PATIENT IS:

MANUAL WHEELCHAIR POV/SCOOTER POWER WHEELCHAIR
SUPPLIER SIGNATURE: _____ **DATE:** _____