Environmental Accessibility Adaptations (Home Modifications) Provider Order

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.

This provider order form must be signed by a licensed health care professional. Submitting this form is an attestation that environmental accessibility adaptations are necessary to avoid the risk of hospitalization.

Complete and submit this form with the *Medi-Cal – Prior Authorization Request Form – Outpatient* either online (recommended) at **provider.healthnetcalifornia.com** or by **fax at 800-743-1655**.

For healthcare professional only

Member Information

Member name:		**Date of birth:**
Medi-Cal ID:	**Preferred language:**	**Phone:**
Address:		
City:	**State:**	**ZIP:**

Healthcare Professional Who is Authorizing the Order

Physician/healthcare professional name:		
Facility name:	**National Provider Identifier (NPI):**	
Address:		
City:	**State:**	**ZIP:**
Phone:	**Fax:**	**Email:**

Home Modifications Request

Select all that apply.

☐ Ramps to assist member in accessing the home
☐ Grab bars
☐ Doorway widening for members who require a wheelchair (internal or external doors)
☐ Stair lifts*
☐ Making a bathroom and shower wheelchair accessible (e.g., constructing a roll-in shower) *
☐ Installation of specialized electric or plumbing system that is necessary to accommodate the member's medical equipment/supplies*
☐ Other_____

*Requires physical or occupational therapy evaluation and report to evaluate medical necessity of the requested equipment or service and two bids which itemize the services, cost, labor and applicable warranties.

24-1139 (10/24)

Personal Emergency Response System (PERS)

Homebound ☐ Yes ☐ No

Does the member have cognitive issues where they would not use the PERS appropriately? ☐ Yes ☐ No

If yes, please describe: _____

Member General Condition

Select all that apply.

☐ Steady gait
☐ Ambulatory with assistive device (cane, walker)
☐ History of falls
☐ Confined to wheelchair
☐ Medications with side effects that increase risk of falls
☐ Supervision/assistance with two or more activities of daily living (ADLs)/instrumental activities of daily living (IADLs) (i.e., hygiene, med management, etc.)
☐ Other_____

Healthcare Professional Attestation

1. **Why is the requested accommodation necessary to avoid the risk of hospitalization?** *(Select all the apply)*

☐ Reduce risks of falls and accidents
☐ Able to reside safely in home with appropriate and cost-effective supports
☐ Other_____

2. **Why is current or past equipment inadequate to meet patient's needs?** (*Select all that apply*)

☐ Member's health conditions have changed
☐ Previous equipment failed to treat symptoms
☐ Member has not received past equipment
☐Other_____

Signature: _____ Date: _____

Authorization Request

Only to be completed by Community Supports provider (servicing organization) after the healthcare professional has signed attestation

Type of request

☐ Initial request ☐ Extension request

☐ Member consented to referral

Community Supports Provider Information (servicing organization)

☐ **Check this box if the healthcare professional is the same as Community Supports provider.**

Organization name:		
Tax identification (ID):	**National Provider Identifier (NPI):**	
Staff name:	**Title:**	
Phone number:	**Fax number**:	**Email:**