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| **DEPARTMENT OF HEALTH SERVICES**Division of Medicaid ServicesF-01213 (02/2017) | **STATE OF WISCONSIN** |
| **ACCESSIBILITY ASSESSMENT REQUEST** |
| **INSTRUCTIONS:** | Completion of this form is not required through Wisconsin State Statute; however, completion of this form is an IRIS program requirement. Personally identifiable information on this form is collected to verify that the request is complete, and will be used only for this purpose. See page 2 of this form for detailed instructions. |
| **NOTE:** | Vendors conducting the assessment cannot be affiliated with companies hired to provide the recommended services. Prior to the use of IRIS funds being used for a home modification, you will be required to provide property owner permission in writing. |
| This form should be used when requesting one of the following: |
| * Home Modifications
* Vehicle Modifications
* All Adaptive Aids
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| **SECTION I – DEMOGRAPHICS (ALL FIELDS MUST BE FILLED)** |
| Participant’s Name (Last, First)      | Date of Birth      |
| Target Group      | Address      |
| Phone Number      | County of Residence      |
| IRIS Consultant      | Guardian’s Name (if applicable)      |
| Guardian’s Address      | Guardian’s Phone Number      |
| Follow-Up Contact: [ ]  Participant [ ]  Guardian | Best Time to Contact: [ ]  Morning [ ]  Afternoon [ ]  Evening |
| **SECTION II – HOME MODIFICATION** |
| I am seeking recommendations for a home modification | **[ ]** Yes | [ ]  No | [ ]  Not Applicable |
| I own my home and my name is on the mortgage/deed. | **[ ]** Yes | [ ]  No | [ ]  Not Applicable |
| I am a renter and have permission from my landlord to do modifications | **[ ]** Yes | [ ]  No | [ ]  Not Applicable |
| My signature below indicates that I am aware of and approve of the modifications to the property that I own and/or manage. |
| **SIGNATURE** – Landlord | Date Signed |
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| **SECTION III – VEHICLE MODIFICATION** |
| I am seeking recommendations related to a vehicle modification. | **[ ]** Yes | [ ]  No | [ ]  Not Applicable |
| I own my vehicle and my name is on the title. | **[ ]** Yes | [ ]  No | [ ]  Not Applicable |
| **SECTION IV – ASSESSMENT** |
| Please provide detailed information about how you are living your day-to-day life. Be specific about the challenges that are keeping you from meeting your long term care goals and/or needs. |
| 1. | In my day-to-day life, I need assistance with the following that impact my safety, independence and mobility: | [ ]  Preparing Meals[ ]  Entering/exiting my home[ ]  Driving | [ ]  Bathing/dressing[ ]  OtherPlease explain:       |
| 2. | Barriers to my independence in my home, neighborhood and community include: | [ ]  My bathroom[ ]  My kitchen[ ]  My doorways[ ]  My living areas[ ]  My bedroom | [ ]  My vehicle[ ]  Areas outside my home[ ]  OtherPlease explain:       |
| 3. | Describe any other relevant information or obstacles that affect your safety, independence or mobility. |       |
| 4. | Accessibility assessors may have different recommendations depending on your current health issues. Please share any relevant information about any medical conditions, current or upcoming, that may impact your independence. |       |
| My signature below authorizes the IRIS consultant agency to share the information I provided on this form with a qualified vendor to perform an accessibility assessment. I understand that having an accessibility assessment done does not guarantee that a home modification, vehicle modification, or adaptive equipment will be paid for with IRIS funding. I confirm the information I shared on this request form is accurate and true. |
| **SIGNATURE** – Participant/Guardian | Date Signed |
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| **INSTRUCTIONS FOR COMPLETING THE ACCESSIBILITY ASSESSMENT REQUEST** |
| **Who Should Use This Form**This form should be completed by participants in the IRIS program wishing to have an accessibility assessment. |
| **How to Complete This Form** |
| 1. **Electronically:** This form is to be completed and submitted electronically. This document is a fillable Microsoft Word document. TAB or CLICK between fields.
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| 1. **Non-Electronically:** Print and complete the document. Be sure handwriting is clear and legible. Submit to the IRIS consultant agency by fax or ground mail.
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| **SECTION I – DEMOGRAPHICS (ALL FIELDS MUST BE FILLED)** |
| **Participant’s Name:** Insert Participant’s Name | **Date of Birth:** Insert Participant’s Date of Birth |
| **Target Group:** Insert Participant’s Target Group | **Address:** Insert Participant’s Address |
| **Phone Number:** Insert Participant’s Phone Number | **County of Residence:** Insert Participant’s County of Residence |
| **IRIS Consultant:** Insert Participant’s IRIS Consultant | **Guardian :** Insert Guardian’s Name if applicable |
| **Guardian’s Address:** Insert Guardian’s Address | **Guardian’s Phone Number:** Insert Guardian’s Phone Number |
| **Follow-Up Contact:** [ ]  Participant [ ]  Guardian | **Best Time to Contact:** [ ]  Morning [ ]  Afternoon [ ]  Evening |
| Check the appropriate box to indicate which option is true | Check the appropriate box to indicate which option is true |
| **SECTION II – HOME MODIFICATION** |
| I am seeking recommendations for a home modification | **[ ]** Yes | [ ]  No | [ ]  Not/Applicable |
| Check the appropriate box to indicate which option is true |
| I own my home and my name is on the mortgage/deed. | **[ ]** Yes | [ ]  No | [ ]  Not/Applicable |
| Check the appropriate box to indicate which option is true |
| I am a renter and have permission from my landlord to do modifications | **[ ]** Yes | [ ]  No | [ ]  Not/Applicable |
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| **SECTION III – VEHICLE MODIFICATION** |
| I am seeking recommendations related to a vehicle modification. | **[ ]** Yes | [ ]  No | [ ]  Not/Applicable |
| Check the appropriate box to indicate which option is true |
| I own my vehicle and my name is on the title. | **[ ]** Yes | [ ]  No | [ ]  Not/Applicable |
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| **SECTION IV – ASSESSMENT** |
| Please provide detailed information about how you are living your day-to-day life. Be specific about the challenges that are keeping you from meeting your long term care goals and/or needs. |
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| Check the appropriate box to indicate which obstacles require assistance from others. |
| 2. | Barriers to my independence in my home, neighborhood and community include: | [ ]  My bathroom[ ]  My kitchen[ ]  My doorways[ ]  My living areas[ ]  My bedroom | [ ]  My vehicle[ ]  Areas outside my home[ ]  OtherPlease explain:       |
| Check the appropriate box to indicate which obstacles require assistance from others. |
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