DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-02891 (08/2022)

STATE OF WISCONSIN
Wis. Admin. Code § DHS 107.02(3)

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.

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

Reset Form