Home Assessment Evaluation Form

Patient Information

Name: _____

Address: _____

Phone: ( ) _____ Date of Birth: _____

Type of Mobility Assistive Equipment (MAE)

☐ Manual Chair ☐ POV/Scooter ☐ Power Wheelchair

Type of Home

☐ Single Story ☐ Multi-Story ☐ Apt. /Condo ☐ Mobile Home

Handicap Accessible? ☐ Yes (Ramps, Stairs, Elevator) ☐ No

Equipment Trials (make, model, turning radius) :

_____

_____

Home Environment

Are there any factors such as temperature, physical layout, surfaces, or obstacles that will render the PMD unusable in the beneficiary's home?

Does the patient's home provide adequate access between rooms, maneuvering space, and surfaces for the placement of a POV/Scooter?

Bathroom:	☐ Yes	☐ No	Measurements _____
Bedroom:	☐ Yes	☐ No	Measurements _____
Kitchen:	☐ Yes	☐ No	Measurements _____
Hallways:	☐ Yes	☐ No	Measurements _____
Other rooms:	☐ Yes	☐ No	Measurements _____

Supplier Attestation:

I have completed an assessment of the patient's home and conclude based upon this information the patient's home will accommodate the following MAE(s): **(CIRCLE ALL THAT APPLY)**

Manual Chair POV/Scooter Power Wheelchair

Date of Home Assessment: _____

Supplier Signature: _____ Date: _____