☐ Living Choice ☐ Medically Fragile

REQUEST FOR ENVIRONMENTAL MODIFICATIONS

Member Name			
Last		*First*	*Middle*
Address			
Street		*City*	*State* *Zip*
Medicaid #			

A. AFFIX PHYSICIAN'S PRESCRIPTION AND PHYSICAL THERAPIST/OCCUPATIONAL THERAPIST EVALUATION			
Primary Diagnosis		Diagnostic Code	
Secondary Diagnosis		Diagnostic Code	
Related Diagnosis		Diagnostic Code	

B. AFFIX BID(S) AND JUSTIFICATION FOR VENDOR SELECTION

C. REQUEST FOR APPROVAL (to be completed by Transitional Coordinator or Case Manager)

_____ is to provide _____

(as itemized on the attached bid) to the above named Member for a cost of $ _____ payable by *Waiver or Demonstration*. This request complies with the Member's Service Plan and with the Program's procurement procedures for purchase of goods and services. If rental property, signed permission has been obtained from the property owner for the requested home modifications.

TC/CM Agency/Representative			
TC/CM Signature		**Date**	

Administrative Review

☐ Cost > $2,500 – Administrative Review Required

Program Manager or Designee	Date Reviewed

☐ Approved ☐ Denied