





Home Modification Process

AHCCCS
Arizona Health Care Cost Containment System

Home Modifications

- Policy AHCCCS AMPM 1240-I
- Includes but not limited to: ramp, shower, grab bars, widen doors/lever handles, high rise toilet, roll under sink
- Purpose: Deter the risk of an increase in home and community based services or **institutionalization**
- Must have a specific adaptive purpose enabling the member to function with **greater independence** in the home
- Must be **medically necessary** and have an impact on member ability to independently perform **Activities of Daily Living** (ADLs)
- Exclusions: general maintenance, home improvement, repair

Home Modification Request Overview

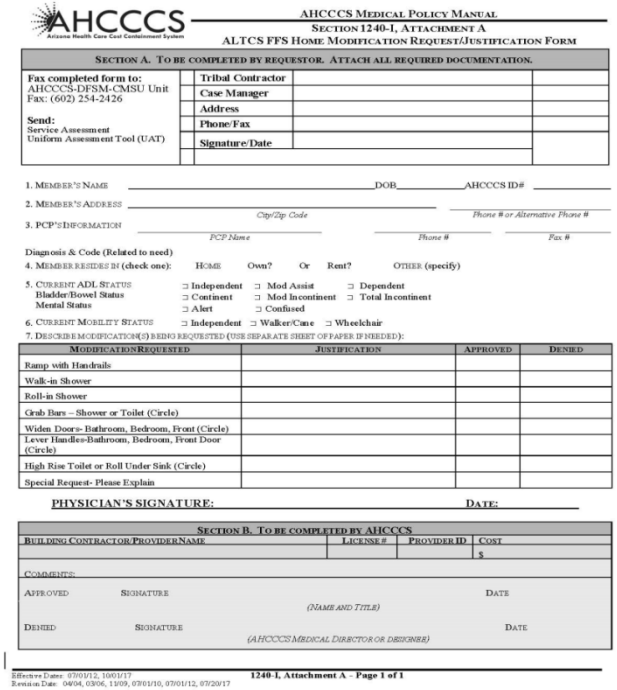
- Bandana reviews initial packet
- FFS Medical Documentation Form (fax cover sheet)
- Uniform Assessment tool
- Service Assessment form
- Home Mod Request/Justification form
- Incomplete packet sent back to Case Manager with reason
- Complete packet reviewed for approval by Nurse

Review Process

- Nurse reviews documentation in packet for medical necessity
- If approved, bid notification letters sent to Case Manager and Contractors – 30 days to submit bids
- Bids reviewed and award letters sent to Case Manager and Contractor
- Contractor receives pended auth –90 days to complete approved modifications
- After project is complete Contractor submits completion docs to AHCCCS – member sign off and after pictures
- Authorization is approved and Contractor is able to submit for billing

Home Mod Request/Justification Form

Common errors
Changes coming



AHCCCS Medical Policy Manual
Section 1240-I, Attachment A
ALTCS FFS Home Modification Request/Justification Form

Section A. To be completed by requestor. Attach all required documentation.

Fax completed form to:
AHCCCS-DFSM-CMSU Unit
Fax: (602) 254-2426

Send:
Service Assessment
Uniform Assessment Tool (UAT)

Tribal Contractor		
Case Manager		
Address		
Phone/Fax		
Signature/Date		

1. Member's Name _____ DOB_____ AHCCCS ID# _____
2. Member's Address _____ _____
City/Zip Code Phone # or Alternative Phone #
3. PCP's Information _____ _____ _____
PCP Name Phone # Fax #

Diagnosis & Code (Related to need)

4. Member resides in (check one): Home Own? Or Rent? Other (specify)
5. Current ADL Status ☐ Independent ☐ Mod Assist ☐ Dependent
Bladder/Bowel Status ☐ Continent ☐ Mod Incontinent ☐ Total Incontinent
Mental Status ☐ Alert ☐ Confused
6. Current Mobility Status ☐ Independent ☐ Walker/Cane ☐ Wheelchair
7. Describe modification(s) being requested (use separate sheet of paper if needed):

Modification Requested	Justification	Approved	Denied
Ramp with Handrails			
Walk-in Shower			
Roll-in Shower			
Grab Bars – Shower or Toilet (Circle)			
Widen Doors- Bathroom, Bedroom, Front (Circle)			
Lever Handles-Bathroom, Bedroom, Front Door (Circle)			
High Rise Toilet or Roll Under Sink (Circle)			
Special Request- Please Explain			

Physician's Signature: _____ Date: _____

Section B. To be completed by AHCCCS

Building Contractor/Provider Name	License #	Provider ID	Cost
			$

Comments:

Approved Signature Date
(Name and Title)
Denied Signature Date
(AHCCCS Medical Director or designee)

Effective Dates: 07/01/12, 10/01/17
Revision Date: 04/04, 03/06, 11/09, 07/01/10, 07/01/12, 07/20/17

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