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| **SECTION A. TO BE COMPLETED BY REQUESTOR. ATTACH ALL REQUIRED DOCUMENTATION.** |
| **Fax completed form to:** AHCCCS-DFSM-PA Unit Fax: (602) 254-2426**Send:**Service AssessmentUniform 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 #*

1. PCP’S INFORMATION

Diagnosis & Code (Related to need)

*PCP Name Phone # Fax #*

1. MEMBER RESIDES IN (check one): HOME Own? Or Rent? OTHER (specify)
2. CURRENT ADL STATUS

Bladder/Bowel Status Mental Status

* Independent □ Mod Assist □ Dependent
* Continent □ Mod Incontinent □ Total Incontinent
* Alert □ Confused
1. CURRENT MOBILITY STATUS □ Independent □ Walker/Cane □ Wheelchair
2. 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 |
| DENIED | SIGNATURE | *(NAME AND TITLE)*DATE |
| *(AHCCCS MEDICAL DIRECTOR OR DESIGNEE)* |