

# 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: \_\_\_\_\_