# 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: _____