CARELINC
Home Medical Equipment & Supply

MOBILITY HOME ASSESSMENT EVALUATION FORM

PATIENT INFORMATION

NAME: ____

ADDRESS: ____

PHONE: ______________________ DATE OF BIRTH: ____________________

PATIENT REQUESTED TYPE OF MOBILITY ASSISTIVE EQUIPMENT (MAE)

☐ MANUAL WHEELCHAIR ☐ POV/SCOOTER ☐ POWER WHEELCHAIR

TYPE OF HOME

☐ SINGLE HOME ☐ MULTI –STORY ☐ APT./CONDO ☐ MOBILE HOME

HANDICAP ACCESSIBLE? INTERIOR: ☐ NO ☐ YES EXTERIOR: ☐ NO ☐ YES
(RAMPS, STAIRS, ELEVATOR)

COMMENTS:

____

____

____

HOME ENVIRONMENT

*ARE THERE ANY FACTORS SUCH AS TEMPERATURE, PHYSICAL LAYOUT, SURFACES, OR OBSTACLES THAT WILL RENDER THE MAE UNUSABLE IN THE BENEFICIARY'S HOME?

HAS THE ABOVE-PRESCRIBED EQUIPMENT BEEN DEMONSTRATED TO ENSURE USABILITY IN THE FOLLOWING LOCATIONS:

BATHROOM ☐ YES ☐ NO COMMENTS: ______________________________

BEDROOM ☐ YES ☐ NO COMMENTS: ______________________________

KITCHEN ☐ YES ☐ NO COMMENTS: ______________________________

HALLWAYS ☐ YES ☐ NO COMMENTS: ______________________________

OTHER ROOMS ☐ YES ☐ NO COMMENTS: ______________________________

SUPPLIER ATTESTATION

I HAVE COMPLETED A PRELIMINARY ASSESSMENT OF THE PATIENTS HOME AND CONCLUDE THAT, BASED UPON THE ABOVE INFORMATION, THE MOST APPROPRIATE TYPE OF POWER MOBILITY DEVICE FOR THIS PATIENT IS:

☐ MANUAL WHEELCHAIR ☐ POV/SCOOTER ☐ POWER WHEELCHAIR

SUPPLIER SIGNATURE: ______________________________ **DATE:**____________

Account #: ________________ RSFM01202