# 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  
- [ ] BEDROOM  
- [ ] KITCHEN  
- [ ] HALLWAYS  
- [ ] OTHER ROOMS

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<tr>
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<th>YES</th>
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<th>COMMENTS:</th>
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<tr>
<td>BATHROOM</td>
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## SUPPLIER ATTESTATION

I HAVE COMPLETED A PRELIMINARY ASSESSMENT OF THE PATIENT’S 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