Reanimations

Service Authorization Request
Home Modification Services

Name: ID#: DOB:
SAR #: SAR PC ID: SAR Submit Date:

Met	Not Met	N/A	Criteria to Approve Service– Add-On Budget Service
☐	☐	☐	The home to be modified is a private residence owned by the individual or his/her family (natural, adoptive, or foster family) or the residence is rented by the individual or his/her family and the requested item is portable.
☐	☐	☐	The requested Home Modification(s) is intended to increase the individual's capability to access his/her environment and are of direct or remedial benefit to the individual or in some way related to the individual's disability.
☐	☐	☐	The individual does not receive Residential Supports or live in a licensed residential facility.
☐	☐	☐	The individual receives Supported Living and owns the home or the home is rented by the individual and the requested item is portable and can be removed if the person moves.
☐	☐	☐	The requested item is necessary to ensure the health, welfare, and safety of the individual or to enhance the individual's level of independence.
☐	☐	☐	The request includes purchases, installation, maintenance, or the repair of home modifications required to enable the individual to increase, maintain or improve their functional capacity to perform daily life tasks that would not be possible otherwise.
☐	☐	☐	The request includes a Letter of Medical Necessity (LMN)/ assessment written and signed by the physician, physician assistant, nurse practitioner, or other licensed professional (i.e. PT, OT, ST), that identifies the Member's needs and how the modification will meet those needs. The written recommendation drives the request for the modification, outlines the medical necessity, and is obtained to ensure that the equipment will meet the needs of the individual. The written assessment is less than one calendar year old (from receipt date of the request) and explains how the modifications requested address a need that cannot be met by equipment or supplies on the State Medicaid Plan.
☐	☐	☐	The request must include a Certificate of Medical necessity (CMN)/ Prescription signed by a physician, physician assistance, or nurse practitioner for the requested Home Modifications regardless of any other approval requirements. The physician's signature is less than one calendar year old on the date the request was submitted. Note: A physician's statement of medical necessity is not required for repairs.
☐	☐	☐	The request includes three (3) separate, comparable quotes that are less than 90-days old on the date the request was submitted. Two (2) separate quotes may be submitted with explanation present. One (1) quote required for repairs.
☐	☐	☐	The quotes submitted contain the following information: labor amount and cost, itemized list of materials and the cost for each item.

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☐	☐	☐	**The requested item(s) may include, but is not limited to:** a. Ramps and Portable Ramps; b. Grab Bars; c. Handrails; d. Lifts, elevators, manual, or other electronic lifts, including portable lifts or lift systems that are used inside an individual's home; e. Porch stair lifts; f. Modifications and/or additions to bathroom facilities; g. Widening of doorways/hallways, turnaround space modifications for improved access and ease of mobility, installation of pocket doors, swing-clear (recessed) hinges, modification of door swing direction, excluding locks that restrict an individual's rights; h. The following specific specialized adaptations: 1. Shatterproof windows; 2. Floor coverings for ease of ambulation for individuals with mobility limitations; 3. Modifications to meet egress regulations directly related to the modification requested; 4. Automatic door openers; 5. Medically necessary portable heating and/or cooling adaptation to be limited to one unit per individual; 6. Installation of rounded counter tops; 7. Lowering of shelves / closet dowel rods / cabinets; 8. Protective covering for a ramp; 9. Wall coverings to prevent damage
☐	☐	☐	This request includes a plan for how the Member and family will be trained on using the equipment.
☐	☐	☐	The request is not for replacement of equipment that has not been reasonably cared for and maintained.
☐	☐	☐	Repair only: Equipment to be repaired is owned by the individual or his/her family.
☐	☐	☐	Repairs Only: Item was purchased through the waiver or purchased prior to waiver participation and the item is identified within the service definition.
☐	☐	☐	Repairs Only: Cost of the repair does not exceed the cost of purchasing a replacement item.
☐	☐	☐	The request does not include service or maintenance contracts or extended warranties.
☐	☐	☐	The request does not include adaptations that add to the total square footage of the home except when necessary to complete an adaptation (e.g., in order to improve entrance/ egress to a residence or to configure a bathroom to accommodate a wheelchair.
☐	☐	☐	The request does not include central air conditioning; general plumbing; swimming pools; Jacuzzis.
☐	☐	☐	The request does not include fences.
☐	☐	☐	The request does not include equipment or supplies purchased for exclusive use at school or home school.
☐	☐	☐	The request does not include new construction, costs associated with building a new home, financing of a new home, and/or down payment on a new home.

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☐	☐	☐	The request does not include items that would normally be available to any child and are ordinarily provided by the family.
☐	☐	☐	The request does not include locks that are used to restrict an individual's rights.
☐	☐	☐	The request does not include adaptations or improvements or repairs to the residence which are of general utility and are not of direct or remedial benefit to the individual or in some way related to the individual's disability.
☐	☐	☐	The service is limited to expenditures of $50,000 of supports (ATES and Home Modifications combined) over the duration of the waiver.
☐	☐		The requested service is individualized, specific, and consistent with symptoms or confirmed diagnosis under treatment, and not in excess of the member's needs.
☐	☐		The requested service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide.
☐	☐		The requested service is furnished in a manner not primarily intended for the convenience of the member, the member's caretaker, or the provider.

Initial Review:

All Criteria Met: ☐ YES – APPROVE ☐ NO (Send to Clinical Reviewer)

UM Reviewer Name, Credentials: Date:

Comments:

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Clinical Review:

☐ Approved ☐ Send to Peer Review

Clinical Reviewer Name, Credentials: Date:

Comments:

IMPORTANT NOTE:

- Once you've completed and signed this form, please send it to info@reanimations.org. To verify your service approval, please email mcastro@reanimations.org
- In evaluating requests for prior authorization, the need for treatment or services will be considered from the standpoint of medical necessity only. An approval of this request does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish eligibility at the time of service.
- For services of repair, remodeling, maintenance (Landscaping, handyman, and more), and new construction not funded by Medicaid/Medicare, please also contact us at info@reanimations.org. We will have special prices for you, and we can negotiate. A portion of your payment for these services will be used by Reanimations to provide services to uninsured individuals, even to pay for services not covered by Medicaid for its beneficiaries.