(Evaluator Logo)

UPMC Community HealthChoices

Exhibit B Evaluator Report

Independent Home Evaluation

Date of Evaluation:

Name:
Member ID:
Address:

Participants Functional Goals

Medical / Other Info

☐ CVA ☐ Cardiac ☐ COPD ☐ DM ☐ OA ☐ Parkinson's

☐ MS ☐ CA ☐ ALS ☐ Other:

Height: Weight: Dominant Hand:

Pain Level: Location (pain):

Fall History: Where?

Aide Assistance: Hours per day: Days per week:

Pt sleeps Sleep preference? Bed type:

Who lives in the house with you?

Home Info *(areas accessed by participant if applicable)*

Home Type: Total Floors: How does pt. access home?

Bathrooms

How Many: Main Location: Other Location:

Main Bath

Bath Set-up: Shower Head: Bath / Shower Height:

Toilet Height: Toilet Shape: Sink Style:

Grab Bars (location):

☐ Bath-Front ☐ Bath-Center ☐ Bath-Back

☐ Toilet-Side ☐ Toilet-Back ☐ Toilet Across

Kitchen (condition) –

Doorways / Thruways

Front (1): Family Room: Kitchen: Bathroom (1): Bedroom:

Front (2): Basement: Rear: Bathroom (2): Garage:

Other:

Stairs

Location: # steps: 13 Width (bottom): (top): Rail:

Location: # steps: Width (bottom): (top): Rail:

Location: # steps: Width (bottom): (top): Rail:

Location: # steps: Width (bottom): (top): Rail:

Current Assistive Devices

☐ Walker	☐ Rollator	☐ Cane	☐ WC (manual)	☐ WC (transport)
☐ WC Power	☐ Scooter	☐ Shower Chair	☐ Tub Bench	☐ Toilet Frame
☐ HH Shower	☐ Grab Bar	☐ Hospital Bed	☐ 3-1 Commode	☐ Ramp
☐ Stair Glide	☐ Life Alert	☐ Power Lift Recliner	☐ Other:	

WC Measurements *(occupied):*

Overall Width: Overall Depth: Height to Knees:

Working Order? Changing WC's Soon?

Walker / Rollator Width:

Functional Status

Transfers: Ability on stairs:

Mobility (in home): Primary device used:

Mobility (outside): Primary device used:

Self-care: Household activities:

Enter/exit home: Phone use:

Physical / Functional Concerns

1.
2.
3.
4.
5.
6.

Evaluator Comments / Summary:

Note: Recommended modifications are based on specific participant requirements. Any alterations should be discussed with the evaluator that completed the evaluation.

Therapist Name / Title: Chris Chovan, OTR/L, ATP
Company Name: UPMC Home Health
Phone Number: 724-591-4703
e-mail: chovanc2@upmc.edu

Summary of Necessary Home Adaptations

Participant Name: Member ID:

Evaluator Name: Chris Chovan, OTR/L, ATP

Evaluator Phone: 724-591-4703

Physical / Functional Concerns

1.
2.
3.
4.
5.
6.

Recommended Adaptations

1.
2.
3.
4.
5.
6.

Recommended DME

1.
2.
3.
4.
5.
6.
7.
8.

The recommended adaptations listed above have been determined to be of a functional benefit to the participant by the evaluator. The purpose of these recommendations is to help enable the participant to live with improved safety and independence in the home. **Note:** These recommendations are subject for review by your Managed Care Organization and this is not a statement of approval.

"By signing next to "Participant Signature" you, the participant or legal representative for the participant, indicate that you agree with these recommendations and that you wish to have these adaptations completed. This form will be sent in support of your request for home adaptation coverage to your Community HealthChoices Managed Care Organization for review.

Participant Signature:_____ Date:

Evaluator Signature:_____ Date:

Submit