CS Environmental Accessibility Adaptation
All Counties
Version 2

Environmental Accessibility Adaptations (EAA), also known as Home Modifications, are physical adaptations to a home that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function with greater independence in the home; without which the Member would require institutionalization.

Individuals are directly responsible for paying their own living expenses.

Submit completed form and supporting documentation to the UM Prior Authorization fax (833) 305-3130.

All fields with an * are required.

SECTION 1 – REFERRAL INFORMATION

Referral Date	
Referral Type	☐ Community Referral ☐ Identified by Molina ☐ Self-Referral ☐ Other:
Referring Organization Name	
Referring Organization NPI	
Referring Individual First Name*	
Referring Individual Last Name*	
Referring Individual Relationship to Member*	
Referring Individual Phone Number*	
Referring Individual Fax Number*	
Referring Individual Email Address*	

SECTION 2 – MEMBER INFORMATION

Member First Name*	
Member Last Name*	
Date of Birth*	
Medi-Cal CIN	
Preferred Written Language	
Member Email Address	
Member Primary Phone Number	
Member Residential Address*	
City*	

State*	
Zip Code	
Is the member currently experiencing homelessness?	☐ Yes ☐ No ☐ Unknown

SECTION 3 – AUTHORIZED REPRESENTATIVE INFORMATION

Member has Authorized Representative	☐ Yes ☐ No
Authorized Representative First Name	
Authorized Representative Last Name	
Authorized Representative Relationship to Member	
Phone Number	
Email Address	
Mailing Address	

SECTION 4 – CLINICAL INFORMATION

Primary Diagnosis	
ICD-10 Code	
Secondary Diagnoses	
Primary Care Provider	
Behavioral Health Provider (if applicable)	
Recent Hospitalization Within Past 30 Days	☐ Yes ☐ No
If Yes, Discharge Date	

SECTION 5 – SERVICE INFORMATION

Request Information*

Service Start Date:

Service End Date:

Eligibility Criteria*

Molina Enrollment:

☐ Enrolled in Medi-Cal with Molina

Member must meet all applicable eligibility requirements for Environmental Accessibility Adaptations.

☐ Member requires physical adaptations to the home to ensure health, welfare, safety, or increased independence within the home environment.

☐ Requested adaptation is medically necessary and directly related to the member's health condition or disability.

☐ Requested adaptation is not the responsibility of the property owner, landlord, or another funding source.

☐ Member is not receiving duplicative support through another State, local, or federally funded program.

☐ Member consented to Environmental Accessibility Adaptations referral.

Requested Environmental Accessibility Adaptation*

Check all requested services:

☐ Wheelchair Ramp (accessing the home)

☐ Grab Bars

☐ Stair Lift

☐ Doorway Widening (for members who require wheelchair access)

☐ Bathroom and Shower Accessibility Modifications

☐ Personal Emergency Response System (PERS)

☐ Other: _____

Service Need Description*

Describe the member's functional limitation and how the requested adaptation will support the member's ability to safely remain in the home and avoid institutionalization:

SECTION 6 – REQUIRED DOCUMENTATION

Please attach all supporting documentation required for review.

☐ Completed EAA Physician Request Form

☐ Clinical Documentation Supporting Medical Necessity

☐ PT Evaluation (if applicable)

☐ OT Evaluation (if applicable)

☐ Supporting Diagnosis Documentation

☐ Vendor Quote / Estimate (if available)

☐ Additional Supporting Documentation

SECTION 7 – ATTESTATION

Member Consent*

☐ I attest that the member and/or authorized representative has consented to this Community Supports referral.

Referral Attestation*

☐ I attest that the information provided in this referral is accurate and complete to the best of my knowledge.

This section must be completed only by the member's treating physician or primary care provider (PCP). The treating physician or PCP should review the requested Environmental Accessibility Adaptation, provide clinical justification supporting the member's need for the requested service, and attest that the information provided is accurate and complete to the best of their knowledge.

TREATING PROVIDER CERTIFICATION	
PCP/Treating Provider Name*	
PCP/Treating Provider Specialty*	
Office Address*	
Phone Number*	
Fax Number*	
E-mail	

Clinical Justification*

Please provide a brief written evaluation describing how the requested equipment or service meets the needs of the member. Please send clinical notes and any supporting documentation if applicable.

Physician Attestation*

☐ I attest that the information provided in this referral is accurate and complete to the best of my knowledge.

Treating Physician Name (Printed)

Treating Physician Signature

Date: