



Australian Government

Department of Veterans' Affairs

AL05, AL10 & AL15 Home/Access Modifications Assessment Form

for all major modifications (bathrooms, ramps, lifts etc)

Provider Hotline: 1300 550 457 (metro) 1800 550 457 (country) - choose Option 1 for Aids & Appliances provided under the Rehabilitation Appliances Program (RAP).

This form is to be used for requesting items through the Rehabilitation Appliances Program. For prior approval items, please attach clinical justification or use DVA specified forms.

The provider is responsible for ensuring that the client is aware that their personal information is to be forwarded to DVA, and companies authorised by DVA to deliver products, for determining and/or providing benefits under the *Veterans' Entitlements Act 1986*. The information will be treated in a confidential manner. However, in certain circumstances it may be used for clinical review, audit or management purposes or disclosed to the client's local medical officer.

Provider Details

☐ OT ☐ Other (Specify Profession)

Provider Stamp (if applicable)

Name

Provider number

Employer

Address

POSTCODE

Phone number

Fax

Phone number

E-mail

Entitled Person/Delivery Details

Surname

Given name(s)

Date of birth

DVA file number

Gender

☐ Male☐ Female

Card type

☐ Gold☐ White - please contact DVA to check eligibility under the client's Accepted Disability(ies). Please call **1300 550 457** (as above).

Does the entitled person live in a Residential Aged Care Facility?

☐ No☐ Yes - ACFI Classification not yet assigned☐

ACFI Classification:

Does the ACFI classification contain one high domain or two or more medium domain categories?

☐ No☐ Yes - (Refer to DVA)

Does the entitled person receive help under Home Care Package Level 4 (formerly EACH)?

☐ No☐ Yes - please contact DVA

Entitled person's contact phone number and alternate contact number

Alt.

Residential address

POSTCODE

Name File No.

Address of residence of proposed modification
 POSTCODE

These items require DVA Prior Approval

To finalise request for any major modification (non access)

Please complete pages **1** to **8** AND page **11**.

For access modification - stair climber/lift/ramps (fixed or demountable, platform steps for walking frames)

Please complete pages **1** to **11** inclusive.

Modification(s) details

1: Description of modification being requested.

☐ Bathroom modification

☐ Stair lift/Lift

☐ Ramp

☐ Other modification

2: Does this request relate to repairs or replacement of existing structures which could be considered normal household maintenance?

No ☐

Yes ☐

3: Is the residence structurally sound and in good condition?

No ☐

Yes ☐

4: Are there alternate facilities/ access in the residence which could be utilised?

No ☐

Yes ☐

5: Does this modification provide direct access to/from the property/residence?

No ☐

Yes ☐

N/A ☐

6: Was this residence purchased before any knowledge of any foreseeable problems that might arise from a disability?

No ☐

Yes ☐

7: Length of time the Beneficiary has lived in this residence.

8: Is the Beneficiary considering relocation?

No ☐

Yes ☐

Name

File No.

Diagnosis/Medical History/Prognosis details

9: Please specify period post surgery/hospital admission.

10: Medical history - list all previous and current conditions along with relevant prognosis.

Consider the possible prognosis when assessing for major modifications as these may take several months to complete and carry a degree of disruption in the home while in progress.

12: Is the Beneficiary's ability likely to improve with treatment or time?

No ☐ Yes ☐

13: Comments (include information on any recent or planned OT or PT intervention to improve function).

14: Social situation:

☐ Lives alone
☐ Lives accompanied - amount of time another is present (per 24 hrs)

 hrs

Comments

Name

File No.

15: Please provide more details of type and frequency of assistance:

Type of assistance

Frequency

Community nursing

No ☐

Yes ☐

Home Care

No ☐

Yes ☐

Meals on Wheels

No ☐

Yes ☐

Does the GP home visit

No ☐

Yes ☐

Other formal supports

No ☐

Yes ☐

Family support

No ☐

Yes ☐

Home Care Level 2 (formerly CACP) or Home Care Level 4 (formerly EACH)

No ☐

Yes ☐

Are the formal/informal supports able to assist with personal care ADL's?

No ☐

Yes ☐

Are the Beneficiary's supports able to safely assist the person to access or use the area considered for modification?

No ☐

Yes ☐

Comments

Name

File No.

16: Description of residence:

Living in:

- ☐ House
- ☐ Unit
- ☐ Retirement village
- ☐ Relocatable home
- ☐ Other - please specify

Is this residence likely to be able to meet the long-term needs of the Beneficiary (e.g. would this residence still meet the Beneficiary's needs should he/she become wheelchair dependent)?

No ☐ Yes ☐

Is this residence:

- ☐ Owned by Beneficiary
- ☐ Owned by relative
- ☐ Government owned housing
- ☐ Rented

If not self-owned, has the owner's approval been granted **and** supplied with this application?

No ☐ Yes ☐

Is this residence subject to strata and company title (Body Corporate)?

No ☐ Yes ☐ ► Has the Body Corporate approval been granted **and supplied in writing** with this application?

No ☐ Yes ☐

17: Clinical and Functional Assessment:

Cognition (actively participates in tranfers, ability to learn new techniques):

Upper **and** Lower Limb Function (ROM, strength, co-ordination etc):

Balance

Sitting:

Standing:

18: Mobility:

Mobility Indoors **and** Outdoors (include mobility aids used and distance):

19: Transfer skills from:

	<i>Transfers independently?</i>		<i>Aids used</i>	<i>Are transfers safe?</i>	
Chairs	No <input type="checkbox"/>	Yes <input type="checkbox"/>	<div></div>	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Bed	No <input type="checkbox"/>	Yes <input type="checkbox"/>	<div></div>	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Toilet	No <input type="checkbox"/>	Yes <input type="checkbox"/>	<div></div>	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Car	No <input type="checkbox"/>	Yes <input type="checkbox"/>	<div></div>	No <input type="checkbox"/>	Yes <input type="checkbox"/>

20: ADL:

Comment on level of independence or assistance:

Dressing:

Bathing:

Continued next page...

Name

File No.

Toileting:

Continence (Bowel and Bladder):

Housework:

Laundry:

Mail collection/Rubbish management:

Shopping:

Banking:

Driving:

Name

File No.

21: Is the Beneficiary currently independent in accessing/using the area proposed for modification (e.g. accessing their bathroom and showering independently in the case of bathroom modification)?

No ☐ Yes ☐

22: Is the Beneficiary unsafe in accessing/using the area proposed for modification?

No ☐

Yes ☐

► Please provide a detailed descriptive **activity analysis** of the person's current level of performance and include what level of supervision/assistance is required and describe who is currently providing this assistance.

23: Does the Beneficiary have access to a toilet, bathroom and sleeping area on ground level?

No ☐ Yes ☐

24: Does the Beneficiary have access to a toilet, bathroom and sleeping area on the one level?

No ☐ Yes ☐

25: Please comment on simpler options already trialed or in place:

Non-structural modifications (e.g. grab rail installation, shower screen removal, rails to the stairs, non slip treads).

Rehabilitation appliances (e.g. bath boards, tub transfer benches, walking sticks, wheeled walkers, rails).

Modified behavioural techniques (e.g. sitting on bath board and lifting legs into bath, two feet per step pattern, rationalising number of times stairs are used daily).

Name File No.

To finalise request for any major modification (non access)

Please complete pages **1** to **8** AND page **11**.

For access modification - stair climber/lift/ramps (fixed or demountable, platform steps for walking frames)

Please complete pages **1** to **11** inclusive.

Access Modifications - Stairlift/Lift/RAMPS - fixed or demountable, platform steps for walking frames

Use in conjunction with pages 1 to 11 of AL05, AL10 and AL15 Home/Access Modifications Assessment form.

26: Has a physiotherapy assessment/treatment program to address mobility/stair climbing commenced or has a referral been organised?

No ☐ Yes ☐



Attach any relevant Physiotherapy reports.

27: Name and contact details of physiotherapist.

Name of physiotherapist

Address

POSTCODE

Phone number

Fax number

E-mail

28: Is this request supported by the veteran's Physiotherapist?

No ☐ Yes ☐ Unsure ☐

29: Is the property situated on an unusually steep or rugged block?

No ☐ Yes ☐

Street access:

Terrain

Backyard:

Terrain

Stair climbing: Front steps:

Number

Existing rail(s): ☐ On one side only ☐ On both sides ☐ None

Back steps:

Number

Existing rail(s): ☐ On one side only ☐ On both sides ☐ None

Internal steps:

Number

Existing rail(s): ☐ On one side only ☐ On both sides ☐ None

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Name	<input type="text"/>	File No.	<input type="text"/>
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Time taken to ascend stairs sec

Time taken to descend stairs sec

Frequency of stair access times per day

30: Describe activity analysis of stair climbing: (include reference to foot clearance, shortness of breath, level of assistance required, is stair climbing currently being achieved).

Ascent

<input type="text"/>
<input type="text"/>
<input type="text"/>

Descent

<input type="text"/>
<input type="text"/>
<input type="text"/>

31: How would an access modification impact the Beneficiary's functional independence (proposed use of the modification)?

<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>

32: Has the area proposed for modification been measured for:

The positioning and width of doorways and the direction of swing of doors?

No ☐ Yes ☐

Dimensions of landings (in accordance with circulation spaces at doorways)?

No ☐ Yes ☐

Relevant Aust standards (e.g. 1:14 for ramps) and so as not to encroach onto sewage or drainage systems, another's property, public property, public property or crown land?

No ☐ Yes ☐

Name File No.

Prescriber Recommendation

Is a major modification being recommended by you?

No ☐ Yes ☐

Please outline the main goals of the modification

Recommended Modification specifications:

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

Checklist

To avoid delays, please use this checklist to ensure the completeness of this request.

- ☐ Attachment A: Medical Information Questionnaire, completed by GP, and attached.
- ☐ Sketch of existing floor plan of residence (include multi-storey floor plans).
- ☐ Plan(s) of existing area to be modified (include dimensions).^{1.}
- ☐ Plan(s) of proposed modifications (include dimensions).^{2.}
- ☐ Photos of existing area to be modified.
- ☐ If possible/appropriate, video of the person accessing their existing area to be modified.

^{1.} For bathroom modifications plans should include all relevant fixtures e.g. shower, bath, vanity, toilet, doorways, door swing, windows, power points, light switches, shower rose or hose, taps, rails etc.

^{2.} For major access modifications plans should include all relevant fixtures e.g. landing sizes, width of doorways, presence of security screens, direction of door swing, sewage outlets, garden beds, fall of the land proposed for modification, suggested positioning of stairlift/lift, windows, power points, light switches, rails etc.

35: Date of assessment.

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36: Prescriber's signature.



Date

/	/
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