** Housing Modification Assessment Report**

**ACC**

**257**

**- Standard and Complex Modifications**

Complete this form to provide ACC with a comprehensive report of the client’s housing modification needs and options.

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| 1. ACC DETAILS |  |
| ACC Client Service staff name:       | ACC Office:        |
| Phone number:       | Email address:       |
|  |
| 2. CLIENT DETAILS |  |
| Client’s full name:       | **Claim number**:       |
| Preferred name:       | Date of birth:       |
| Address where the modifications are to take place:  |       |
| Current address (if different from address above, eg rehabilitation unit, motel, family):  |       |
| Home phone:       | Mobile phone:       |
| Home fax:       | Work phone:       |
| Email address:       | Ethnicity:       |
|  |
| 3. CLIENT’S REPRESENTATIVE’S DETAILS | IF APPLICABLE |
| Name of client’s representative:       | Relationship to client:       |
| Postal address:  |       |
| Phone number:       | Email address:       |
|  |
| 4. PARTICIPANTS IN ASSESSMENT |  |
| Name of participant | Relationship to client | Contact phone number | Nature of participation(eg meeting, phone contact, etc) |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|  |
| 5. CLAIM DETAILS |  |
| Date of injury:  |       |
| Brief description of injuries:  |       |
| Strengths (eg regular gym user, good balance, supportive family, strong upper limbs):  |       |
| Primary functional (activity) limitations as a result of the injury:  |       |
|  |
| 6. NON-INJURY-RELATED NEEDS |  |
| Does the client have a non-injury-related disability or illness (eg arthritis, heart disease) that adversely affects them gaining access or enjoying freedom of movement and living independently in their home? |  [ ]  No – Go to Section 7 [ ]  Yes |
| If YES describe the disability or illness and its functional (activity) impact  |
| Disability/illness:  |       |
| Functional (activity) impact:  |       |
| Likely duration of non-injury related disability/illness: [ ]  Less than 6 months [ ]  6 to 12 months [ ]  Up to 2 years [ ]  Ongoing |
| Is the client’s health or well-being likely to deteriorate (eg poorly controlled diabetes, emphysema, multiple sclerosis, etc)? [ ]  No [ ]  Yes |
| If YES describe risk and likely functional (activity) impact:  |       |
|  |
| 7. SOCIAL AND OTHER CONSIDERATIONS |  |
| **Note: ACC does not fund modifications to hospitals, hostels, hotels, motels, rest homes and other similar organisations. If the residence for modification is one of the above contact ACC for advice before proceeding with the assessment.** |
| Property owner details |
| The client is:  | [ ]  the property owner of the home being modified |
|  | [ ]  renting the home being modified from Housing New Zealand Corporation (HNZC) |
|  | [ ]  renting the home being modified from a private landlord |
|  | [ ]  a dependant/minor/other, please describe:  |       |
| Where the client is NOT the property owner of the home being modified, please provide the property owner contact details below |
| Property owner name:       | Property owner phone number:       |
| Property owner address:  |       | Property owner email address:       |
| Living Environment |
| How long has the client resided in this home? |       years       months  |
|  | [ ]  N/A (eg has not taken possession of home/building new home |
| Have modifications previously been undertaken to this home? | [ ]  Yes  | [ ]  No |
| If YES, please describe:  |       |
| Do these modifications meet the client’s assessed injury-related needs? | [ ]  N/A | [ ]  Yes  | [ ]  No |
| If NO, please explain:  |       |
| Have the client’s injury-related needs changed since any previous modification to this home? | [ ]  N/A | [ ]  Yes  | [ ]  No |
| If YES, please describe how these needs have changed:  |       |
| Is the client intending to move from a home that presently meets their injury-related needs? |  | [ ]  Yes | [ ]  No |
| If YES, when does the client intend to move?  |       |
| If YES, what is the reason for the move?  |       |

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| 8. LIVING SITUATION FOLLOWING PROPOSED MODIFICATIONS |  |
| Living arrangements: | [ ]  Client will live alone | [ ]  Client will live with family/whanau | [ ]  Client will live with people other than family/whanau |
| Describe the household:  |       |
| Describe the contribution to housekeeping of the client and others in the household: |       |
| Other relevant details (eg if the client has responsibility for childcare that may have an impact on the modifications; family members work outside the home):  |       |
|  |
| 9. CLIENT EQUIPMENT |  |
| Equipment the client will be using in their modified home |
| **Item** | **Dimensions** | **Turning circle/****Circulation space**(mm) |
|  | Width (mm) | Length (mm) |
| Manual wheelchair:  | [ ]  Self propelling  |       mm |       mm |       mm |
|  | [ ]  Attendant propelled |       mm |       mm |       mm |
| [ ]  Powerchair – model:       |       mm |       mm |       mm |
| [ ]  Hoist – model:       |       mm |       mm |       mm |
| [ ]  Shower commode chair |       mm |       mm |       mm |
| [ ]  Walking frame |       mm |       mm |       mm |
| [ ]  Standing frame |       mm |       mm |       mm |
| High/Low bed [ ]  Single [ ]  Double |       mm |       mm |       mm |
| Anticipated long term equipment needs (ie equipment that is not needed now, but is likely to be needed in the foreseeable future eg shower commode, wheelchair, walking frame) |
| **Item** | **Dimensions** | **Turning circle/****Circulation space** |
|  | Width (mm) | Length (mm) | (mm) |
|       |       mm |       mm |       mm |
|       |       mm |       mm |       mm |
|       |       mm |       mm |       mm |
|  |
| 10. HOME ENVIRONMENT |  |
| Briefly describe the client’s unmodified home environment (eg two storey home, sloping section, bungalow) |
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| 11. ASSESSMENT FINDINGS |  |
| Outline the client’s current functional (activity) limitations, the effect these limitations have within the client’s home environment, and the key considerations to be taken into account to deliver a practicable outcome that addresses the client’s injury-related needs. The Housing Assessor should relate the impact of the client’s functional (activity) limitations to the specific area of the home where a barrier has been identified. There should be a logical flow between the issues identified within the environment, what the environment needs to look like in the future (Key Considerations) and the activities or functions (Outcomes) that the client will be able to achieve with the environmental changes in place.**EXISTING ENVIRONMENT** – Describe how the client’s injury-related needs impact on their ability to access the following areas of their home in the absence of any modifications.**KEY CONSIDERATIONS** – Identify the key issues and specifications in relation to the client’s needs that will need to be considered and addressed to deliver a practicable housing modification solution.**OUTCOMES** – Identify the outcomes that need to be achieved to meet the client’s injury-related needs.**NB: Attach photos of areas of difficulty in the home** |
| **A. GAINING ACCESS TO THE HOME** |
| **EXISTING ENVIRONMENT** | Cause of limitation | **KEY CONSIDERATIONS** | **OUTCOMES** |
| Injury | Non-injury |
| Existing points of entry/egress |
|       | [ ]  | [ ]  |       |       |
|       | [ ]  | [ ]  |       |       |
|       | [ ]  | [ ]  |       |       |
| Access from vehicle to home (if applicable) |
|       | [ ]  | [ ]  |       |       |
|       | [ ]  | [ ]  |       |       |
|       | [ ]  | [ ]  |       |       |
|  |  |  |  |  |
| **B. FREEDOM OF MOVEMENT AND LIVING INDEPENDENTLY WITHIN THE HOME** |
| **EXISTING ENVIRONMENT** | Cause of limitation | **KEY CONSIDERATIONS** | **OUTCOMES** |
| Injury | Non-injury |
| Bedroom |
|       | [ ]  | [ ]  |       |       |
|       | [ ]  | [ ]  |       |       |
|       | [ ]  | [ ]  |       |       |
| Bathroom |
|       | [ ]  | [ ]  |       |       |
|       | [ ]  | [ ]  |       |       |
|       | [ ]  | [ ]  |       |       |
| Kitchen and dining room |
|       | [ ]  | [ ]  |       |       |
|       | [ ]  | [ ]  |       |       |
|       | [ ]  | [ ]  |       |       |
| Toilet |
|       | [ ]  | [ ]  |       |       |
|       | [ ]  | [ ]  |       |       |
|       | [ ]  | [ ]  |       |       |
| Laundry |
|       | [ ]  | [ ]  |       |       |
|       | [ ]  | [ ]  |       |       |
|       | [ ]  | [ ]  |       |       |
| Other areas |
|       | [ ]  | [ ]  |       |       |
|       | [ ]  | [ ]  |       |       |
|       | [ ]  | [ ]  |       |       |

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| **C. SUMMARY OF NEEDS** |
|       |
| **D. NEW HOME** If the client is intending to build a new home, specify any environmental needs specific to the person’s injury-related requirements. (Non-injury-related requirements are the client’s responsibility) |
|       |
| **E. ADDITIONAL COMMENTS** Please provide any other information that is relevant to this assessment including client comments/requests |
|       |
|  |
| 12. ASSESSOR DECLARATION |  |
| By completing and submitting this assessment report I confirm that the information is complete and accurate. I have carefully considered and documented the client’s injury-related functional (activity) limitations and the effects their environment has on the client gaining access to, and moving freely within, the home. I have considered and noted the issues that will need to be considered and addressed to achieve a practicable outcome to meet the client’s needs. |
| **Signature:** | **Date:** |
| Name:       |
| Vendor name:       | Vendor number:       |
| Email:       | Phone number:       |
| Date of referral:       | Date of assessment:       | Purchase order number:       |

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