

## Home Evaluation for a Power Operated Vehicle (POV) Form

Questionnaire completed by: \_\_\_\_\_ Phone # \_\_\_\_\_  
(please print)

Name of Physical Therapist \_\_\_\_\_ Fax # \_\_\_\_\_

Group # \_\_\_\_\_ Patient Name \_\_\_\_\_

Subscriber # \_\_\_\_\_ Subscriber Name \_\_\_\_\_

Referral # \_\_\_\_\_ Address \_\_\_\_\_  
(if applicable) (street)

\_\_\_\_\_ (city) (state) (zip)

**Please complete all the questions fully. Failure to do so will result in delay or possible denial of claims.**

Limited Functions	Impairment	Comments
Is the patient unable to move around in their residence? If so, why?		
Why is the patient unable to operate a manual wheelchair?		
Is the duration of need greater than 6 months?		

Demonstrated Capabilities	Yes	No (Reason)
Can the patient safely operate the controls of a POV?	<input type="checkbox"/>	
Can the patient safely transfer in and out of POV?	<input type="checkbox"/>	
Does the patient have adequate trunk control to safely ride in a POV?	<input type="checkbox"/>	

Residence Use:	Description	Comments
Activities for which equipment is primarily to be used		
Are the doorways for access to the home and within the home accessible by a POV?	Yes <input type="checkbox"/> No <input type="checkbox"/>	

**Provider's Signature:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Provider's Blue Cross Blue Shield Identification Number or Tax Identification Number:**

\_\_\_\_\_