Home Modifications / Special Medical Equipment
Rental Property Agreement

Today’s date: __________________

I, the owner/manager of the rental property located at:

Street: _____________________________             Apt/floor: ______________________

City: ___________________________  State: ___________       Zip: _____________________

Occupied by:

Medicaid Recipient Name: ________________________________________________________

Authorize the installation of the following equipment/modifications at the above residence:

Equipment/Modifications:

_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

By signing below, I also understand and agree with the following:

1. The equipment/modifications are for the use of the Medicaid recipient and will be removed when the recipient no longer resides in the dwelling.
2. The Executive Office of Health and Human Services (EOHHS) will not fund any costs associated with restoring the dwelling to the original condition.
3. Any equipment/modifications are considered the property of the Medicaid recipient.

Name of Owner/Manager (please print): __________________________________________

Signature: ____________________________________________________ Date: ___________

Name of Medicaid Recipient (please print): ______________________________

Signature of Recipient/Representative: _______________________________ Date: __________