Home Modifications / Special Medical Equipment

Today's date: ____________________

I, the owner of the 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 (please print): ____

Signature: ____ Date: ___________

Name of Medicaid Recipient (please print): ____

Signature of Recipient/Representative: ______________________________ Date: __________