Virginia Department of Behavioral Health & Developmental Services

Request for Durable Medical Equipment Services

Form Instructions: **For *Repair, Safety Assessment, Pressure Washing or Custom Adaptation* requests, please complete Page 1 & 2 of this form and return. For *Training, Educational or Community Events*, please complete Page 3 of this form and return. For *PT, OT, Technical Assistance or Accessibility* requests, please complete Page 4 of this form and return.**

This form must be filled out completely. Incomplete forms will be returned to the Requestor.
Return this form to MRETeam@dbhds.virginia.gov.
Forms will ONLY be accepted by email unless prior arrangements have been made with MRE Management.

Date of Request:	Date of Birth:
Individual Name:	Preferred Name:

☐ This individual has an intellectual or developmental disability as defined by the VA Code

Does the individual have Medicaid? ☐Yes ☐No

Does the individual have a waiver? ☐Yes ☐No

Have you contacted your local DME for your request? ☐Yes ☐No

What were the barriers that hindered the DME Company from assisting you?

_____

_____

_____

CLIENT INFORMATION

Indicate individual's type of residence: ☐ Family Home ☐ Group Home ☐ ICF

Name of Group Home/ICF (if applicable):	
Street Address:	Apt/Suite:
City/Town:	Zip Code:

DAY SUPPORT INFORMATION

Does the individual attend a Day Program? ☐ Yes ☐ No

Day Program Name:	
Street Address:	
City/Town:	Zip Code:
Days and Hours of Attendance:	

REQUESTOR INFORMATION

Community Service Board:	
Requestor Name:	Relationship:
Phone Number:	Email:

ADDRESS OF SERVICE:

Street Address:	
City/Town:	Zip Code:
Contact Name:	Phone:

Service Type *(Please select all that apply)*

Individual

☐ Repair ☐ Safety Assessment ☐ Pressure Washing ☐ Custom Adaptation

For Pressure Washing Requests Only: Do you have an outdoor spigot to accommodate? ☐ Yes ☐ No

List Equipment in need of service below.

Equipment Type:	
Make/Brand Name:	Model:
Description of Problem/Consult Needs:	

Equipment Type:	
Make/Brand Name:	Model:
Description of Problem/Consult Needs:	

For Multiple Individuals, please fill out the following information *(Please select all that apply)*

☐ Pressure Washing Clinic ☐ Safety Assessment/Repair Clinic

For Pressure Washing Requests Only: Do you have an outdoor spigot to accommodate? ☐ Yes ☐ No

Approximate Number of Pieces of Equipment: _____ (Example: 25-30)

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Training/Educational Event/ Community Event

ORGANIZATION INFORMATION

Name of Organization, Business or CSB:	
Street Address:	Apt/Suite:
City/Town:	Zip Code:
Contact Person:	Phone:
Email Address:	

Event Type *(Please select all that apply)*

☐ MRE/DME/AT Training ☐ Emergency Preparedness for Caregivers ☐ Community Event

Do you have an area or room to conduct the Training? ☐ Yes ☐ No

Does room have an audiovisual screen for PowerPoint Trainings? ☐ Yes ☐ No

Does the room have tables and chairs? ☐ Yes ☐ No

How many people does the room accommodate? (Approximate) _____

Approximate number of Attendees: _____

Please list any information that may be helpful to know about the site:*(Ex. Don't park on the left-side of the building)*

_____

_____

_____

Who will be invited to your Community Event Training? *(Ex. General Public, Nurses, Program Managers, DSPs)*

_____

_____

Any additional information that might be helpful: *(Ex. We prefer to schedule training for a Wednesday morning)*

_____

_____

_____

_____

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Physical Therapist/Occupational Therapist/Technical Assistance/Accessibility

CLIENT INFORMATION

Indicate individual's type of residence: ☐ Family Home ☐ Group Home ☐ ICF ☐ Apartment

Name of Individual:	
Street Address:	Apt/Suite:
City/Town:	Zip Code:

REQUEST TYPE

Request Type *(Please select all that apply)*
☐ PT Consult ☐ OT Consult ☐ Technical Assistance Consult ☐ Mini-Accessibility Assessment

MEDICAL HISTORY

Diagnosis:	
Any recent changes in Health Status? (stroke, hospitalizations, surgeries, etc.) ☐ Yes ☐ No	
If so, what kind?	
Is the individual Ambulatory or Non-Ambulatory? ☐ Ambulatory ☐ Non-Ambulatory	
Ambulatory Foot Orthotics? ☐ Yes ☐ No	Hand Splits? ☐ Yes ☐ No
Wheelchair Type: ☐ Manual ☐ Power	Wheelchair Brand:
Does the wheelchair Tilt? ☐ Yes ☐ No	Wheelchair Ramp? ☐ Yes ☐ No
Stairs? ☐ Yes ☐ No	Stair or Chair lift? ☐ Yes ☐ No
Patient Lift? ☐ Yes ☐ No If yes, is the lift ☐ Electric ☐ Manual	
Does the individual ride in an Accessible vehicle while seated in a wheelchair? ☐ Yes ☐ No	

SEATING ASSESSMENT

Date of Last Seating Assessment:
Where was this assessment conducted?
What DME Vendor conducted this assessment?
Are there any issues with the wheelchair?