Texas Department of Aging
and Disability Services

Community Based Alternatives

Documentation of Completion of Purchase

Form **3848**
December 2000

SECTION I–ASSESSMENT

1. Participant Name	2. Type of Purchase ☐ A- Minor Home Modification ☐ B- Adaptive Aid	3. Date Completed/Delivered
4. Participant Address		
5. Name of Person Completing Orientation for Adaptive Aid	6. Title	7. Date of Orientation
8. Qualifications of Person Completing Orientation		
9. Description of Job or Item:		

10. Method of Delivery	For items costing less than $500: ⇨ 11.A. Name of Telephone Contact ⇨ 11.B. Date of Contact	For items costing more than $500 or when a home visit was made ⇨ 12. Date of Home Visit

SECTION II–MINOR HOME MODIFICATION

1. Name of Inspector	2. Qualifications (use attachment if necessary)

3. Determination
☐ A- Modification completed according to TAS requirements. (No specifications were required.)
☐ B- Modification completed according to specifications and TAS requirements.
☐ C- Modification NOT completed according to specifications or TAS requirements.

4. Comments:

Signature–Inspector _____ Date _____

SECTION III–PARTICIPANT SATISFACTION

1. Name of Responsible Party (if applicable)	2. Satisfaction ☐ A- Participant satisfied with home modification/adaptive aid. ☐ B- Participant NOT satisfied with home modification/adaptive aid.

3. Training/Orientation
☐ A- Additional training/orientation hour(s) are required.
☐ B- NO additional training/orientation hour(s) are required.

Signature–Agency Representative _____ Date _____

4. Participant Satisfaction Assessment Upon Home Visit
☐ A- I am now satisfied with the home modification/adaptive aid.
☐ B- I am still NOT satisfied with the minor home modification/adaptive aid.

Signature–Nurse/Therapist _____ Date _____ Signature–Participant/Responsible Party _____ Date _____

SECTION IV–ADAPTIVE AID (Nurse/Therapist Documentation of Participant Needs)

1. Nurse/Therapist Determination
☐ A- The item meets the documented needs of the participant.
☐ B- The item does NOT meet the documented needs of the participant.

2. Name of Nurse/Therapist (please type or print)

Signature–Nurse/Therapist _____ Date _____

SECTION V–HCSS AGENCY

Name of HCSS Agency Representative	Name of Agency	Vendor No.

Signature–HCSS Agency Representative _____ Date of Signature _____ Date Sent to Case Manager _____