



City of Seal Beach

CDBG Bathroom Accessibility Program

Doctor's Instructions & Medical Assessment Form

Dear Doctor,

The City of Seal Beach has received a limited amount of federal funding to assist eligible senior residents with essential home safety and accessibility modifications. These improvements are provided at no cost to qualifying residents.

To ensure this grant program reaches those with the greatest medical and mobility needs, we respectfully request that you complete the attached Doctor's Assessment Form for your patient. Your honest and accurate responses will help the City of Seal Beach fairly prioritize applications, taking into account both health needs and household income.

All information you provide will be kept strictly confidential and used only to evaluate this specific application.

We sincerely appreciate your assistance in helping Seal Beach seniors remain safe, healthy, and independent in their homes.

Instructions:

- Please complete all sections of the attached form.
- Return the completed form by fax, email, or U.S. mail using the contact information below.
- To avoid delays in processing, please return the form within 10 business days.

Thank you for your support in this important program.

Return Form To:

City of Seal Beach c/o CivicStone, Inc.

4195 Chino Hills Parkway, #267

Chino Hills, CA 91709

Email: monique@civicstone.com

Phone: 909-364-9000

Fax: 909-333-4030



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Patient Name: _____

1. Mobility Assessment

Does the patient have a condition that causes difficulty moving around the home (e.g., using stairs, navigating doorways, getting in/out of bed, sitting/standing)?

- Yes No

If yes, indicate severity:

- Mild – Some limitations but generally independent
 Moderate – Requires assistance or adaptive equipment
 Serious/Severe – Significant difficulty; patient is largely dependent

Is the condition:

- Temporary Permanent

2. Pain With Movement

Does the patient experience pain during movement (e.g., walking, bending, sitting, standing)?

- Yes No

If yes, indicate severity:

- Mild – Occasional discomfort, does not limit daily activities
 Moderate – Frequent pain, some limitations in daily activities
 Serious/Severe – Constant or intense pain, limits basic mobility

Is the condition:

- Temporary Permanent

3. Balance or Fall Risk

Does the patient suffer from balance issues or high risk of falls?

- Yes No

If yes, indicate severity/frequency:

- Mild – Occasional unsteadiness, minimal risk
 Moderate – Frequent balance problems, moderate fall risk
 Serious/Severe – Significant instability, high fall risk

Is the condition:

- Temporary Permanent

4. Additional Comments (Optional)

Please describe any other relevant conditions affecting the patient's ability to safely navigate their home:

Physician Signature: _____ Date: _____

Physician Name: _____ Phone: _____