HOUSING GUIDELINES AND CONSIDERATIONS
Revised 2016

This housing information was prepared by a subcommittee appointed by the Board. It is being provided as general information and to assist with giving appropriate considerations for housing issues that may arise while working with an injured worker during the rehabilitation process. It is not all-inclusive or specific to an individual injured worker's needs. It is to be used as a guide to explore the housing issues with all parties. The HOUSING GUIDELINES AND CONSIDERATIONS are not to be construed as having statutory authority but are instead intended as guidelines to the parties in considering housing issues. The HOUSING GUIDELINES AND CONSIDERATIONS were, however reviewed and approved by the State Board of Worker's Compensation before publication.

PURPOSE OF PAPER

The purpose of this paper is to help clarify the various housing issues which exist in some catastrophic workers' compensation situations. The primary guideline for determining housing needs is based on Georgia State Board of Workers Compensation Rule 200.1, which states the understanding that part of the mandatory Rehabilitation Services is to "coordinate reasonable and necessary items and services to return the employee to the least restrictive lifestyle possible." When necessary, this specifically includes suitable housing. While the catastrophic rehabilitation supplier is required to be the point person to coordinate these services, all parties are charged with the fulfillment of this goal.

OVERVIEW

Rule 200.1 gives little guidance as to what constitutes "reasonable and necessary items and services" and only states that they may include "housing and transportation". Unfortunately, thus far, there has only been one case-law decision rendered on housing in the catastrophic claim setting, Pringle v. Mayor & Alderman of the City of Savannah, 223 Ga.App.751; 478 S.E.2d 139(1996). The essence of this Court of Appeals decision addressed whether the Board had the right to mandate the provision of payments towards housing costs by the employer/insurer. In the Court's analysis, housing accommodation needs could be addressed as a medical need if the authorized treating physician(s) prescribes them. (Id. @ 752). It also found that, pursuant to Rule 200.1 of the Workers' Compensation Act which clearly requires the employer/insurer to provide necessary modifications to the employee's home, it is also a rehabilitation need. While the solution reached in Pringle is specific to the facts of that case, the case highlighted the issue that appropriate accessible housing may require alternative solutions if the employee's prior living arrangement is incapable of being modified. (Id. @ 754). In addition, the Court further held that the Board was within its discretion to mandate the employer/insurer fund additional payment towards housing costs if they result from needs necessitated by the compensable on-the-job injury. Finally, this decision also established the proposition that the employee is expected to contribute towards his/her housing, as well.

There are many shades of grey in the interpretation of "least restrictive lifestyle". Each catastrophic claim, by its very nature, is different. It would be impossible to construct a law or rule on housing that would accommodate the varied needs of individual injuries. However, there is an evaluation process that should be implemented when addressing housing needs. To begin with, although ***payment*** for suitable housing is a claims issue in catastrophic injury cases, ***suitable housing*** itself is a rehabilitation issue. ***Every Catastrophic Rehabilitation Supplier ("Rehabilitation Supplier") is responsible for researching and coordinating appropriate housing for catastrophically injured employees whose injuries necessitate***

special housing accommodations. As such, it is imperative that the Board assigned Rehabilitation Supplier spearheads the implementation of this issue and is *always* kept in the loop. However, parties must recognize that the Catastrophic Rehabilitation Supplier is *not* the housing "expert". The Rehabilitation Supplier's role is the coordination of the consultation of experts and the gathering and dissemination of information of the various options to all parties upon which housing decisions may be made.

This paper is intended to serve as a guideline to suppliers involved in developing proposed housing plans. ***All phases of the housing process should be covered under specific rehabilitation Independent Living Plans***. All the plans should designate responsibilities with timeframes. The Rehabilitation Supplier should share information with all parties as soon as it is obtained.

REHABILITATION SUPPLIER RESPONSIBILITIES

The two guiding principles that should remain in the forefront of the suitable housing evaluation are "safety" and "accessibility". This necessarily contemplates the employee's functional status. It may take several experts in varying fields to reach a reasonable conclusion.

The Rehabilitation Supplier should immediately commence activity to obtain information regarding the injured worker's housing situation and preliminary functional and medical information from the authorized treating physician and/or appropriate healthcare provider.

The Rehabilitation Supplier should identify medical and/or functional factors related to the injury, including but not limited to the following, as determined by the authorized treating physician and/or appropriate healthcare provider: **[Note: a formal evaluation of the employee's functional abilities and deficits may be required to obtain all of the necessary information listed below.]**

- Working diagnosis(es)
- Level of independence or dependence with activities of daily living (ADLs)
- Fine and gross motor dexterity
- Strength and endurance capacity
- Cognitive function and any cognitive related deficits
- Sensory deficits (auditory, tactile, visual)
- Trunk and lower extremity function.
- Gait and balance
- Prognosis and timeframe for improvement
- Co-morbid factors including any age-related factors
- Projected discharge date
- Projected home health care and/or nursing care upon discharge to home
- Projected surgeries and/or rehabilitation treatment

At the initial appointment, the Rehabilitation Supplier should obtain information from the injured worker and/or the injured worker's family/friends as to the injured worker's housing arrangement, including but not limited to the following:

- Address, including county and state
- Type of dwelling (home, trailer, apartment, condominium, etc.)
- Number of floors (ranch, 2 story, split-level, etc.)
- Cost of rent or mortgage
- Identify the people who reside in the dwelling
- Age of dwelling
- Number of bedrooms and number of bathrooms including half baths

Flat lot or uneven, hilly terrain
Location of exterior doors
Presence of interior/exterior steps or stairs and handrails
Type of vehicle injured worker drives and where it is parked at the dwelling

The next step for the Rehabilitation Supplier is to visit the residence to perform a preliminary assessment of needs.

If adaptations are necessary, and it appears that the dwelling can be modified:

The Rehabilitation Supplier will discuss with the authorized treating physician (ATP) to obtain a prescription for a home evaluation by a professional who is experienced in home accessibility issues (i.e. O.T., P.T. etc.).

The Rehabilitation Supplier should then proceed to coordinate and attend the home evaluation to determine:

If modifications can be completed to the dwelling.
Specifications of what modifications should be done.
If modifications will be suitable for long-term housing needs.

The Rehabilitation Supplier will then coordinate the acquisition of bids by licensed contractors and then present the bids to the parties.

The parties will determine if the modifications are economically feasible.

When a decision has been reached and if a contractor is selected (See Section VI), the modifications should be implemented.

If it appears that the dwelling cannot be modified for long-term accessibility, the Rehabilitation Supplier should then proceed with these additional steps:

Discuss with all parties preferences for suitable long-term (permanent) accessible housing options, taking into account all of the variable considerations (See Section V below).

If there is an agreement among the parties on a specific option, focus research and availability on that type of long-term (permanent) housing selected. Research should include costs for comparative purposes. Present research to all parties. If all parties agree on a selection, proceed to implementing the necessary steps to bring it to fruition.

If there is not an agreement among the parties as to which long-term (permanent) accessible housing option is appropriate, then the Rehabilitation Supplier must research all of the appropriate options, given the specific needs of the injured worker. Research should include costs.

If the parties do not agree on any aspect of long-term (permanent) housing, the Rehabilitation Supplier should immediately request a rehabilitation conference (WC-R5) to have the issues addressed by the Rehabilitation Coordinator overseeing the claim.

Prior to the rehabilitation conference, the documentation, reflecting the results of the research, should be distributed to all parties so informed discussions may be held and decisions made at the conference.

The Rehabilitation Supplier will develop an Independent Living Rehabilitation Plan (WC-R2a) which outlines the rehabilitation services, specifically focusing on the housing needs. This should include performing all of the research necessary to address the housing issue. This may require an addendum to an existing plan.

Regardless of the permanent housing decision, if the employee is ready to be discharged from in-patient care, if he/she cannot return to his/her prior living arrangements, and the permanent housing is not yet identified or ready, then temporary housing must be considered and addressed. Likewise, if an employee has already returned to his/her home and it is subsequently being modified, the employee may need to leave the premises during the construction. Temporary housing must be

addressed. It is imperative for the Rehabilitation Supplier to identify this issue as early as possible to avoid decisions having to be made on an emergency basis.

The Rehabilitation Supplier will discuss with all parties the possible Temporary Housing options. The Rehabilitation Supplier will discuss with the ATP to obtain a prescription for temporary housing while permanent housing is being established.

TEMPORARY HOUSING

All parties must be clear that the term "TEMPORARY HOUSING" is not to be confused with long-term (permanent) placement of the injured worker and family of the injured worker. It is considered a "stop-gap" while long-term (permanent) solutions are contemplated and implemented. It should ***never*** be used as an excuse to delay the provision of suitable permanent housing. Extended housing in TEMPORARY HOUSING facilities should be addressed in a revised Rehabilitation Plan.

GENERAL CONSIDERATIONS

It is the Rehabilitation Division's expectation that a family unit, whenever possible, will stay together to include both family and pets. A motel room and/or rooms are not acceptable long term housing except while necessary home modifications are being completed or pending closing on permanent accessible housing.

Prior to exploring options for Temporary/Interim Housing, at *least* the following should be considered:

Disability Type
- What modifications are necessary?
- Will there be attendant care needs?

Family Composition
- Is there a spouse/significant other?
- Are there children living at home? If so, who provides childcare or is there a need for children to be kept in a specific geographical area to attend school?
- Who will care for the pets: i.e., will family/friends or is boarding the pets required?

Pre-Injury Housing
- Are temporary modifications possible?
- Should other accessible properties be considered?

Geographical Convenience
- Medical appointments.
- Community Services.

OPTIONS TO CONSIDER

Assisted Living

Assisted Living may be a consideration for individuals aged 50 and above, if minimum assistance with transfers and ADLs is required. Advantages are socialization and ongoing planned activities, as well as transportation for both medical and non-medical outings. Some also have onsite therapies, pools, hair salons, and physical therapy or gyms. The Rehabilitation Supplier will obtain a referral from the ATP for this option.

Corporate Rental Properties

Furnished apartments that are accessible are available with short-term lease options. These may be appropriate to consider while one's permanent housing needs are being addressed via home modifications or purchase of accessible housing.

Group Home

Group Home may be appropriate for temporary housing for individuals who need accessible housing as well as continuing Medical Services provided by a Specialty Facility outside of the geographical area of permanent housing needs: i.e., for individuals w/dual diagnoses: spinal and traumatic brain injuries. The Rehabilitation Supplier will obtain a referral from the ATP for this option.

Independent Living

Another option for individuals aged 50 and above, with or without a spouse and without dependent is independent living. This option allows for the injured worker to reside in a private apartment and utilize the amenities that are available onsite: i.e., planned onsite and offsite daily activities, available scheduled transportation for outings for medical appointments, as well as leisure activities.

Long Term Stay Motels

Extended stay motels are available that include usually one bedroom, living area with sleep sofa, small kitchenette, and laundry facilities onsite. Accessible rooms are available with roll-in showers in many of these. Rentals can be weekly versus monthly or long-term contracts. The needs of not only the injured worker to include attendant care requirements but also the family unit and /or pets must be considered. This option may require the need for multiple rental units.

Skilled Nursing Facility

If the injured worker requires ongoing licensed nursing care, this type of restrictive facility may prove beneficial during the research for permanent placement. However, this option should truly be limited to individuals that are medically impaired and require that level of nursing care on a continuous basis. The Rehabilitation Supplier will obtain a referral from the ATP for this option.

LONG-TERM HOUSING

Long Term housing options must be thoroughly explored and considered with the goal of providing reasonable and necessary accommodations to return the injured worker to the least restrictive lifestyle possible. Such Long Term Housing shall be considered to be a permanent housing solution if it is the subject of a Partial Stipulated Settlement signed by the parties and approved by the State Board of Worker's Compensation as set forth in Section XII.

GENERAL CONSIDERATIONS

Long-term housing is often the most difficult task the injured worker and the Rehabilitation Supplier will face as a team. There are numerous options to explore and evaluate. A rehabilitation Independent Living Plan needs to be drawn up and submitted to the State Board, even if all parties do not agree. The task of reaching a decision and finalizing the needs is often time consuming. The attending physician and various experts should be consulted for support and ideas on the choices for housing. These guidelines should enable the Rehabilitation Supplier to begin working with the client and family appropriately as soon as possible on permanent housing needs. Of course, in all cases, the insurer and attorneys need to be involved. The Independent Living Plan should include all steps to accomplish the chosen long-term housing solution and should be amended, as needed.

Parties need to remember that housing needs are disability driven and based upon residual functional capacities. Present housing needs are *not* defined by an injured worker's prior living arrangements (e.g. value of home, size of home, number of rooms, etc.). Likewise, design and/or material upgrades, unrelated to safety, function, or accessibility, are not the responsibility of the employer/insurer. Parties are cautioned to anticipate potential changes in functional levels (See Section IX below), especially if resolving by partial settlement (See Section XII below). Due consideration in light of these factors should be given as to who holds title to the home.

OPTIONS TO CONSIDER

It is the responsibility of the Rehabilitation Supplier to investigate multiple options simultaneously to enable the parties to determine which is most appropriate.

Apartment Accommodations

Sometimes an apartment is the best long-term option for housing. The Fair Housing Amendments Act of 1998 prohibits discrimination in housing on the basis of disability. It also states that certain multi-family dwellings designed and constructed for first occupancy after March 13, 1991 must be built in a manner that makes them accessible to persons with disabilities. The Act established design and construction requirements to make these dwellings readily accessible and usable by persons with disabilities. On March 6, 1991, the department published final Fair Housing Accessibility Guidelines to provide builders and developers with technical guidance on how to comply with the Fair Housing Act. Rental offices and sales offices for residential housing are by their nature open to the public and are places of public accommodation. Individuals with disabilities may ask the housing provider to make a reasonable accommodation to a "no pets" policy. Tenants may be required to provide proof of disability and substantiate the need for the service animal. A tenant and the Rehabilitation Supplier should keep in mind the following when looking at an apartment:

Distance from parking.
Age of apartment (newer apartments may require less modification).
Accessibility features of the apartment amenities.
Design features.
Flooring.
Size of and maneuverability between rooms.
Two accessible exits/entrances that may be utilized for emergency or evacuation needs.
Lighting.
Storage.
Accessible bathroom location.
Washer/Dryer locations.
Access to public transportation.

Condominium

The apartment accommodation section gives valid information which is applicable to choosing a condominium. The Rehabilitation Supplier would obtain written verification that the modification can be made.

A condominium is a form of home ownership in which individual units of a larger complex are sold, not rented. These units may be renovated apartments, townhouses, or even

commercial warehouses. Contrary to popular belief, the word “condominium” does not apply to the type of unit itself, but the legal ownership arrangement.

Those who purchase units in a condominium technically own everything from their walls inward. All of the individual homeowners have share rights to most common areas, such as the elevators, hallways, pools, and club houses. Maintenance of these areas becomes the responsibility of a condominium association. Every owner owns a share of interest in the condominium association, plus an obligation to pay monthly dues or special assessment fees for larger maintenance problems.

A condominium arrangement is not the best option for every potential homeowner. There can be a noticeable lack of privacy in the common areas- the pool must be shared with every other condominium owner, for example. Those who would prefer to own all of their amenities and maintain their own lawn and garden may want to pursue single home ownership options instead of a condominium. It can also be more difficult to sell a condominium unit as opposed to a home with acreage. Condominium owners only own their units, not the ground beneath them.

Those who may benefit the most from condominium living are veteran apartment renters who don’t mind having close neighbors. Others may not be capable of external maintenance or the responsibility of lawn care. The overall price of a condominium townhouse may be much lower that an equivalent single-unit home. Buying a condominium does allow equity to build, unlike paying monthly rent in an apartment complex.

One thing to be aware of, when living in a condominium setting, is the political reality of an owner’s association. Decisions may be made in monthly meetings which will cost individual owners more money, but not necessarily deliver equal benefits for all. The potential increase for assessment of fees needs to be considered and agreed upon by the paying party. It can be nearly impossible to avoid being affected by at least one condominium board decision, so active participation in meetings and discussions may be more compulsory than you might expect. Condominium living may be more advantageous financially than apartment rentals, but it does require more active participation in community events.

Modification of an Existing Home

The following is applicable to either the employee’s current home or an existing home that will be purchased. Prior to determining if an existing home is a viable option, there are many variables that need to be considered:
Injured worker’s desire to be in the home.
Condition of the home.
Size of the home (room sizes that will be utilized by the client).
Size of lot.
Slope of lot.
Levels of the home.
Need for public transportation.
Need for school district for children or jobs.
The building of an addition versus elaborate reconstruction.
The cost effectiveness of the modifications and/or additions. Proper analysis by the necessary experts is required for this determination. Remember, these steps need to be included in an Independent Living Plan.

New Home Construction

For the purpose of this housing paper, three building systems will be considered. These include Site-built, Modular, and Manufactured Homes. (See ADDENDUM: Comparative Chart).

Site-built (traditional stick-frame) Home

Homes are built to specifications on site by construction workers, carpenters, electricians, plumbers, etc., who are supervised by the building sub-contractor or general contractor. Homes are built to meet or exceed local/regional code regulations.

Modular Home (pre-fabricated)

Homes are built to the same building codes as Site-built homes, but are constructed off-site usually in a factory setting. Sections of the home are constructed in separate components or modules, which are later assembled on-site, on a foundation which would be similar to a site-built home. Because of the controlled environment during the construction of individual modules, there is a reduction in overall pricing for modular homes, as well as a reduction in the time required to complete the overall construction project.

Manufactured Home (aka mobile home)

The Federal Construction Safety Standards Act (HUD/CODE) requires manufactured homes to be constructed on a non-removable steel chassis. Manufactured homes are built in an assembly-line or factory environment. The building codes are not the same as the building codes for modular or site-built homes. The manufactured home would be transported on wheels, in a single or double-wide configuration, to the land on which it would be placed. Based on the HUD definition, a "mobile home" is a manufactured home which was built prior to the effective date that the Housing and Urban Development (HUD) code went into effect on June 15, 1976.

Facilities

The Rehabilitation Supplier should visit the facilities that are being considered for long-term living options, determine that the needs of the injured worker will be met, and coordinate with the family and the doctor. The following options for long-term housing may be appropriate or not appropriate based on individual needs. Another issue concerns family circumstances and pets. As indicated above, the Rehabilitation Supplier must obtain a referral from the ATP for these options to be considered.

Assisted Living/Nursing Homes

Assisted Living facilities have services available to the residents and a monthly fee is paid often with additional fees for services, such as, cooking, laundry, reminder to take medications, etc. For individuals, aged 50 and above, Assisted Living may be a consideration if the injured worker needs minimum assistance. A clear definition of any and all assistance needed will dictate whether the assisted living facility is appropriate or not. Advantages are socialization and ongoing planned activities, as well as transportation for both medical and non-medical outings. Some also have onsite activities, pools, hair salons, and physical therapy or gyms.

There are several resources available to assess the quality of skilled nursing facilities. MemberoftheFamily.net provides an annual survey rating system for actual potential for (resident) harm, violations, and repeat violations. The Georgia Nursing Home Association (www.gnha.org) offers a comprehensive checklist of what to observe (during a visit), questions to ask yourself and facility staff, and nursing home statistics. Finally, www.Medicare.gov/NHCompare has five-star rating system detailing information about the past performance of every Medicare and Medicaid certified nursing home in the country which can be researched at www.Medicare.gov by geography, proximity, and name. Medicare and Medicaid certified nursing homes are rated as to their last

inspection in the Nursing Home Compare Section. The Rehabilitation Supplier should not rely on this report alone because minimum standards are reflected in the report and conditions change frequently. The Ombudsman in the area of the home may be contacted for the most current information. The Rehabilitation Supplier should perform a site visit prior to the recommendation of a specific facility. The Rehabilitation Supplier should consider that all nursing homes are not appropriate for patients, with tracheotomies, for example. Individualized assistance will need to be addressed and provided separately per physician and physical or occupational therapist recommendations. For example, specific assistance with ADLs or transfers may be indicated. In addition, alternatives to nursing homes may be located at Elder Care Locator at 1-800-677-1166.

Board and Care Homes

Board and Care homes are designed for people who do not meet the needs of independent living but do not require nursing home services. Most provide assistance with some ADLS, for example, eating, walking, bathing, and toileting. Many of these facilities do not take Medicare and Medicaid and are not strictly monitored. The Rehabilitation Supplier would have to carefully research and monitor these facilities.

CCRCS (Continuing Care Retirement Community Services)

The Rehabilitation Supplier would need to use these facilities carefully and determine that the geographic requirements are met. CCRCS housing communities provide different levels of care based on the individual needs from independent apartment to skilled nursing. CCRCS are usually appropriate for ages 50 – 55 and over. The Rehabilitation Supplier would have to check the quality of the facility and nursing home. Most of these facilities require a large payment prior to admission and then no fees are charged. This would be a long-term arrangement and would need to be agreed upon by all parties and care would need to be taken in ensuring that the injured worker's best interest is served.

Specialized Facilities

Long-term specialized facilities would include those meeting the needs of injuries including brain injury, burns, spinal cord, etc. These exist locally and nationwide.

CHOOSING THE CONTRACTOR

There are a few guidelines to explore to avoid an unhappy experience with the contractor. The best way to avoid additional stress and to ensure a good outcome is to choose the correct contractor. The parties are responsible to perform a due diligence investigation of any contractors considered to participate in the housing project. The Employer/Insurer, as the party responsible for payment, shall have the right to choose the contractor from the bids submitted by qualified vendors/contractors. Disputes regarding selection and qualification of the Contractor may be submitted to the Trial Division of the State Board of Worker's Compensation for resolution.

As a reminder, it is the Rehabilitation Supplier's responsibility to gather all information and documentation regarding the housing project, to include the parties, third party vendors, general contractors and all subcontractors. The Rehabilitation Supplier must distribute it all to the parties to the claim. This includes, but is not limited to , licensure, insurance, reports, bids, and designs.

CHECK LIST

All contractors must be licensed through the State of Georgia. It is suggested that the parties require the contractors to produce his/her verifiable license with the submission of any bid. The contractor **should have experience building handicapped accessible homes**. The parties

should ensure that the contractor states in his/her contract that all of the subcontractors utilized will be licensed and insured. For more information you may contact the licensing board for residential and general contractors at their website, www.sos.state.ga.us/plb/contractors .

Check references; ask questions; try to see their work; get as much information as possible.

Did the contractor keep the schedule and contract terms?

Were they pleased with the work?

Did the contractor listen to requests and respect these?

Would they hire the contractor again?

Check the contractor out with the Better Business Bureau, Chamber of Commerce, the Consumer Fraud Unit and/or the District Attorney.

Secure two to three bids that specify the scope of their work so they may be comparable. The bids should specify the duration of their validity.

Obtain a copy of the selected contractor's General Liability Insurance and Workers' Compensation coverage, if required. Parties are advised to verify their validity.

For large scale housing modification or building projects, parties might want to consider including, as part of the contract, a "performance bond". A "performance bond" is additional insurance the general contractor may purchase to cover the cost of the project in the event the general contractor is unable to complete the project (due to illness, death, or bankruptcy). The general contractor must pass both a criminal background and credit evaluation in order to obtain this insurance bond. There is a fee for purchase of the "performance bond", based on value of the project, which may be shown as an option in itemized costs of proposed contract.

The contractor is responsible for knowledge and adherence to all pertinent City/County/State building and zoning codes. Likewise, he/she is also responsible for securing all required building permits and inspections. Parties should include this in the contract.

Make sure that the contract is specific and clear. Some particulars to look for are draw schedules, permits, inspections, and dates to start and complete the project. A "spec sheet" should be attached to the contract, which spells out the specifics of the building project in detail, including, but not limited to, materials to be used, type of faucets, door sizes, water heater, appliances, flooring, paint grade, etc.

The contract should specify requirements for a final payment, i.e., a lien clearance letter, certificate of occupancy, or other necessary documents.

RED FLAG CLUES CONCERNING CONTRACTOR

Cannot produce a valid address or phone number.

Uses undue pressure.

Does not give references.

Prices the project substantially lower compared to other bids.

Quotes a "special price" for anything.

References do not check out.

Unable to verify license and insurance coverage.

Asks for pay 100% up front or an unusual first advance.

If you are asked to sign a completion certificate before the job is done.

GENERAL ACCESSIBILITY

In terms of housing for the catastrophically injured worker, "accessibility" can be generally described as: The provision of specific modifications to the present or future home that will allow the injured worker to

function safely within that environment, where possible, as closely to that which was enjoyed prior to the injury. Present housing needs are *not* defined by an injured worker's prior living arrangements (e.g. value of home, size of home, number of rooms, etc.). Accessibility needs are based upon the disability and function of the Injured Worker.

GENERAL CONSIDERATIONS

Board Rule 200.1 notes that housing is most appropriately addressed in an Independent Living Plan (WCR2-a). Board Rule 200.1 (5) (ii) states "An Independent Living Plan encompasses those items and services, including housing and transportation, which are reasonable and necessary, for a catastrophically injured employee to return to the least restrictive lifestyle possible."

Limitations associated with physical injuries are the most common, and usually the most obvious, issues to be addressed. Less obvious, however, are the limitations associated with cognitive or "unseen" injures and their residual impact on the injured worker and their ability to deal with their environment.

The *Americans with Disabilities Act of 1990 (ADA)*, as amended, was drafted primarily to address commercial and public buildings, employment and related issues. While not mandatory for private residences, this act does, however, provide important and basic guidelines for the design and construction of housing that is compatible with the needs of individuals experiencing physical and/or cognitive impairments. There are no ADA codes applicable to private residences. Primary issues of concern in the development of accessible housing of any type should include, but not be limited to:

- General safety.
- Fire safety: The ability to enter and exit home in a safe and efficient manner, preferably, the ability to exit the home from two (2) distinctly different areas.
- The ability to access the various areas of the home to perform ADLs. These areas include, but are not limited to, the bathroom (including the commode, shower/bath and vanity), the kitchen (including cooking and storage areas), the bedroom (including dresser and closet areas), and the driveway (including a garage or carport).
- The ability to communicate with others outside of the home should a problem develop (police, fire, family).
- Consideration of the injured worker's lifestyle, hobbies, interests, and other avocational activities that were performed prior to the injury.
- The need to relocate for easier access to support programs, medical treatment and/or suitable transportation.
- Family makeup.
- Financial responsibility.

The types and extent of any home modifications are dependent upon the type of injury, the functional limitations associated with the injury, aging factors, and the anticipated level of independent living which the injured worker will likely attain. As such, they are individualized to each case and require the input of multiple experts.

Modifications and issues common to all disability groups include:

- Safety – Preferably two (2) accessible exits from the residence that lead to separate outdoor areas.
- Structural and electrical wiring meeting acceptable building practices and state/local codes.
- Maximized ability to access, use, and move about the residence freely without obstruction or hazard.
- The need to develop creative approaches to individual problems uniquely associated with the injured worker and their functional limitations.

ARCHITECTURAL BARRIER REMOVAL AND OTHER PHYSICAL MODIFICATIONS

Modifications may be necessary to the physical environment for injured workers with mobility, cognitive, visual limitations, and/or other functional limitations. The goal of these modifications is to allow the injured worker to return to the home environment and function independently, as close to the pre-injury level as possible.

Modifications in this area include external ramps, lowered and/or raised countertops, widened doorways, modifications to the bath area to facilitate maximum access and use, in-home ramps and/or lifts, elevators, landscape design and grade, flooring material, etc.

Consideration should also be made for covered access and egress for injured workers who are mobility impaired. Additional consideration should be made regarding modifications to home workshops and other avocational areas that will maximize the injured worker's return to a level of activity enjoyed prior to the injury.

HOUSING CONSIDERATIONS IN ATTAINING AN ACCESSIBLE AND/OR LEAST RESTRICTIVE ENVIRONMENT

Not all injured workers will require these items. Any home modifications should be individualized to that injured worker and the type and level of his/her residual functional limitations. Likewise, design and/or material upgrades, unrelated to safety, function, or accessibility, are not the responsibility of the employer/insurer.

Ramps – Recommended run and rise should be no greater than 1:12 (one inch of rise for every one foot of run). If runs exceed 30 feet, a resting platform will be required with a 5' square platform. Ramps with a grade of 1:12 should have one handrail. Ramps with a grade of 1:10 should have two handrails. These handrails should be placed at 2'8" and a lower guardrail should be centered 7" to the inside of the ramp.

Doorways – Recommended 36" minimum clearance, especially for new construction, for injured workers requiring wheelchairs for mobility. (Width may vary with the type of wheelchair and size of the individual). Maximum 1/2" beveled threshold with 5' x 5' level platform in front of doors and at top of ramp are recommended. Lever type handles are recommended 36" to 38" from the floor.

Hallways – It is recommended that hallways be at least 36", and preferably 42" wide, allowing a mobility- impaired injured worker and a non-mobility impaired individual to be able to pass safely.

Countertops – Desirable height for countertops for mobility-impaired individuals is 34".

Cabinets – Recommended height for mobility-impaired individuals is 44".

Sinks – Top of sink is recommended to be at a height of 33". Faucet sets should be single lever, or, if separate hot/cold, use 2 ½" blade handle.

Flooring – Mobility-impaired injured workers utilizing wheelchairs are best accommodated by hardwood or similar type floors. Linoleum tends to wear excessively.

Lighting – Additional lighting will assist injured workers with low vision limitations in regard to their mobility. Mobility-impaired injured workers would best function with light switches mounted between 36" and 40" from the floor. Outlets should be no less that 18" to 20" from the floor.

Heating and Air Conditioning – For mobility-impaired injured workers, controls should be 36" to 44" from the floor, preferably with lever or push button controls.

Appliances – For mobility-impaired workers, appliances should have front mounted controls. Consider a countertop range and separate oven with side hinge door, and side-by-side refrigerator and freezer.

Bathrooms – Considerations include: Tub vs. shower, handheld shower, single lever mixing, roll in shower, and additional hose length for the handheld showerhead (must be tailored to the individual and the extent of injury and functional limitations). Step-in baths or lifts for entering the bathtub may need to be considered.

Toilets – Recommended toilet height for mobility-impaired individuals is 20" – 22". Toilet centered 18" from sidewall.

Fixtures – Recommendations include: 30" x 48" approach in front of all fixtures. Grab bars should be considered for the tub and shower. There should be knee space under the lavatory with lever type faucets.

Bedrooms – Attempt to insure a 5' turning radius in the bedroom, with furniture in place for mobility-impaired injured workers. Closet bar heights are recommended to be no higher that 54" from the floor, 52" preferred. Beds must be tailored to the individual and the type of injury. Chairs should be sturdy and stable.

HOUSING CONSIDERATIONS RELATED TO SENSORY DEFICITS

In addition to many of the modifications noted above, particular attention should also be paid to:

Visual cues for those individuals experiencing industrial deafness.

- Blinking lights for the telephone, doorbell, etc.
- Accommodations to appliances and other home devices that will allow the injured worker to "see" rather that hear alarms, etc.
- Modifications to communication devices. This would include telephones, televisions, computers, etc.

Auditory cues for the injured worker experiencing industrial blindness, cognitive disorders, or other disorder affecting sight and/or attention and concentration.

- "Talking" watches, appliances and other devices that allow the injured work to hear rather than see actions taking place with microwaves, and other kitchen appliances.
- Creating a "lack of clutter" home space that will allow the injured worker the maximum freedom to fully utilize their home.

Tactile cues for injured workers who are visually and/or cognitively impaired.

- Cueing for appliances and/or electronic devices via raised numerals, Braille patterning or similar configurations.
- Ridges and/or other texture changes approaching doorways, halls, or other various areas.

HOUSING CONSIDERATIONS SPECIFIC TO BURN INJURIES

While considering many of the accommodations noted above, workers who have experienced severe burns will also often require:

Environmental control systems that maintain a constant temperature and humidity range.

Wheelchair access may need to be considered if the injured worker has mobility impairments. (See specifics above).

Inside laundry facilities are imperative to keep sheets and other materials clean. Infection can spread if laundry is taken outside the home.

The burn patient may also require a separate room if he/she has open wounds that are infected. The room must be large enough to accommodate specialty equipment, such as suctioning devices, Pegasus type beds, wheelchairs, etc.

Specialized wiring if custom computer equipment is required to communicate with the hospital, physicians, etc.
Consideration given to building a small, enclosed porch (based upon the need and severity of the burn) with windows so that the person could "be outside" but still not exposed to the sun or in a non-environmentally controlled area.

ASSISTIVE TECHNOLOGY

These are supplemental devices and/or equipment, not necessarily modifications, that allow maximum independent functioning to be reached by mobility, cognitively, visually and/or hearing impaired injured workers.

Computers, computer software, environmental controls, automatic dialers and other similar equipment.
Emergency services contact equipment.
Cell phones, pagers, and other equipment that allow communication during emergencies or medical crisis.
Power doorways and other technological aides to assist in maximizing independence.

MOVING & STORAGE

These issues should be reviewed with parties as part of the planning for accessible housing and included as part of the proposed independent living rehabilitation plan (WC-R2a), when appropriate:

STORAGE

The renovation of an existing living space or building of a new accessible living space may require that the injured worker's (and his/her family's) household goods be temporarily stored in a public facility. Resources include "you store it" facilities found in most communities. The moving company that is moving the contents of the household may offer storage as an added service. Storage costs are based upon size of the space needed. Consideration should be given as to the items being stored and whether a climate controlled facility is required. Most spaces can be leased on a monthly basis. A contract with the storage facility is usually required. The Rehabilitation Supplier will need to discuss the contract and arrangements for funding with the injured worker and insurance carrier prior to the signing of a contractual agreement.

MOVING

Local professional household moving contractors may be needed to move the injured worker's/family's household contents to a storage facility during renovation of living space, temporary housing arrangements, or during construction of a new accessible living space. When obtaining bids for moving the injured worker's household contents, the Rehabilitation Supplier needs to obtain proof of the moving company's vehicle and liability insurance. Parties should consider insuring the contents of the household against damage and loss. The Rehabilitation Supplier will need to discuss specifics of the moving contract (i.e., spacing arrangements, moving boxes purchase, storage, dates/times, and arrangements for payment of contract) with the parties and include the information in the plan.

LONG TERM FACTORS TO CONSIDER FOR AGING INJURED WORKER

As time passes, everyone is affected by the aging process. However, it has been shown that individuals experiencing various types of disabilities may, and often do, encounter these problems much earlier in life and with more dramatic impact upon their ability to function independently than would occur in the general population.

GENERAL CONSIDERATIONS

In general, it is expected that the aging population will include the presence, development and/or increase of the following:

- Need for help with ADLs.
- Fatigue.
- Weakness.
- Arthritis.
- Decreased stamina.
- Decreased brain function.
- Psychological issues.
- Change in nutritional needs.
- Development of Diabetes.
- Increased orthopedic disorders.
- Decreased mobility.
- Hypertension.
- Cardiovascular disease.
- Urinary and/or bowel problems.
- Skin changes.
- Changes in need for and sensitivity to medications.
- Increased reliance on assistive devices and personal care services.
- Social isolation.
- Increased potential for further injuries.

DISABILITY AND AGING

As stated above, individuals with disabilities tend to age faster.[1] A general principal of this concept is the "40/20" rule. This means that functional issues begin to emerge when a person reaches 40 years of age or has been disabled 20 years, whichever comes first. Additionally, a combination of this rule 50/10, 55/5, etc. also seems to carry forth the validity of this phenomenon.

Experts in the field of rehabilitation medicine indicate that individuals with a severe disability age faster.[2] Over the years, the organ system capacity declines gradually, over a 50 to 60 year period, until it reaches 20% to 40% of peak, at about age 75. In people with disabilities, this decline is accelerated from an average of 1% per year in the non-disabled person to between 1.5% and 5% per year depending upon the organ system. Adults who have a disability after maturity seem to

[1] Forman, Lawrence S., et al (2007) Aging and Life expectancy with a Disability.
[2] Kemp, B.J. (2005) What the rehabilitation professional and the Consumer need to know, *Physical Medicine Rehabilitation Clinics of North America*, 16:1

age at a rate faster than normal from that point forward. Those who sustain a disability prior to maturity may never reach that peak capacity.[3]

SPECIFIC DISABILITIES

Each disability has increased areas that appear to be affected more during the aging process.

- Spinal Cord Injuries
  - About 40% of persons with spinal cord injury under the age of 60 need some help with self care, but as they age, this need for assistance increases to 70% at age 75.[4]
  - Loss of lean muscle mass (sarcopenia).
  - Shoulder impingement (shoulders "wear out" after pushing a manual wheelchair for years).
  - Osteoporosis secondary to the inability to bear weight and/or exercise properly.
  - Earlier onset of arthritis.
  - Decreased stamina with the need to utilize power devices such as power wheelchairs.
  - Long term care relationships often become strained and there is a need to change providers.
  - Psychological changes such as depression, isolation and/or avoidance of the public.
  - Change in nutritional needs secondary to lowered metabolic rate, changes in hormones, and less muscle mass.
  - Increased spasticity. Overuse injuries such as carpal tunnel, shoulder and elbow bursitis, potential fractures, kyphosis and scoliosis.
  - Hypertension. Hypertension is nearly twice as common in individuals with paraplegia as in able-bodied verified by controlled studies.
  - Cardiovascular disease. As much as 200% higher incident in individuals with spinal cord injuries.
  - Skin fragility. Aging decreases skin tone and thickness thus leading to an increase in decubitus ulcers and difficulty in healing.
  - Urinary tract infections. 400% higher rate of developing bladder cancer with a long term indwelling catheter.
  - Increased injury potential. Extremity fractures occur in approximately 40% of individuals with long term spinal cord injury.

- Brain Injuries
  - Long term relationships often become strained and there is a need to change providers.
  - Fatigue and loss of stamina due to deconditioning and restricted mobility.
  - Sleep disturbances add to fatigue.
  - Late onset psychosis and possible post-traumatic epilepsy.
  - Decreased sense of smell and tastes cause changes in diet and nutrition.

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[3] Kemp, B.J. (2005) *Living with a Disability: A different way of aging*. UCI Medical Center, Irvine, CA.

[4] *Aging and SCI*, (February 1997). University of Washington, Rehabilitation Medicine, Northwest Regional Spinal Cord Injury System.

- Decreased physical activity can lead to the development of adult onset diabetes.
- Impaired gait secondary to brain injury lead to back and hip problems requiring surgical and/or equipment intervention.
- If seizures present, neurotoxic effects of long-term anti-convulsants must be considered.
- Psychological stress and/or depression develop from the increasing dependency needs, feelings of powerlessness and isolation.
- Social isolation secondary to the inability to participate in physical and social activities.
- Increased risk of repeat traumatic brain injury.

- Amputations
  - Fatigue occurs sooner with limb loss.
  - Weakness and loss of muscle mass due to improper fit of prosthesis.
  - High risk for increased arthritis.
  - May require equipment for mobility assistance.
  - Issues of overuse of unaffected limbs.
  - Personality and other psychological changes secondary to traumatic loss of limbs.
  - Nutritional changes.
  - Impaired gait stresses back and non-impaired leg.
  - Loss of muscle mass may necessitate frequent changes in the prosthesis itself.
  - Skin fragility in the amputation area leads to skin breakdown and decreased ability to heal.
  - Higher risks of frequent falls causing additional injuries.

- Burns
  - There is a high incidence of cancer in burn patients. The scars cause an inflammatory reaction that can lead to malignant lesions. The scar tissue then becomes malignant.
  - The grafted skin also thins out over time and peels off. Hands are especially susceptible to open areas, tenderness and loss of fine motor function.
  - Facial and hand burns can be the most disabling over time. Burns of the feet also present long term problems due to pressure from shoes and scar breakdown.
  - Facial scars can become very tender over time especially if the person does not wear sun protection every day. Hair may stop growing over scarred areas even though it comes back right after the burn.
  - Nerves are trapped in the scars, and many people have chronic pain in some areas of grafting which may increase over time.
  - Scar tissue may change, become infected and/or inflamed and close monitoring of the burn area is required especially as the individual ages.

- Vision

- Traumatic vision loss increases in individual's potential to develop coronary artery disease by 2-3 times over non-traumatic vision loss subjects.[5]
- Travel becomes more difficult secondary to cognitive changes associated with aging.
- Co-morbid factors, osteoporosis, vascular disease, or other health problems may decrease the ability to perform ADLs previously performed with little or no difficulty.

ADDITIONAL THINGS TO CONSIDER AND DISCUSS

LOCATION OF ACCESSIBLE LIVING SPACE

Consideration should be given to the proximity of the living arrangements of the injured worker to medical care, community services, school districts (if there are children in the family), and access to public transportation. The safety of the proposed neighborhood should also be considered, especially when the injured worker's mobility has been compromised.

POWER GRID/GENERATOR

Consideration should be given to the injured worker's specific need for life sustaining electrical medical equipment, power wheelchair, and/or heating/cooling of the living space. When such conditions exist, serious consideration should be given to living in a location which has access to multiple sources of power or circuits (power grid). In addition, a backup generator for crisis situations should be considered. Special consideration should be given to alternative power sources when the condition of the employee requires the use of life sustaining equipment.

WATER VS. SEPTIC TANK

Many areas within the State of Georgia do not have access to city or county sewer systems. Sewer systems may provide advantage of less upkeep in future, and may be consideration if choice is available. If septic tank is necessary, each county has specific requirements for "perk" tests for the land where building is proposed. Each county may require specific type of septic tank system to be used, how the "drain field lines" will be placed, etc. The Rehabilitation Supplier must be sure that housing contractor who will be completing housing project is considering these needs as part of the overall bid/projected costs. The maintenance/upkeep of the system should be specifically addressed.

GARAGE VS. CARPORT

A carport gives protection from the weather, but presents exposure to the elements when going into the home. A large enough garage with a direct entry into the home eliminates this exposure. However, this issue may be creatively addressed on other ways (i.e. awning extended from garage). Such Garage/Carport should contemplate accessibility to the home for the injured worker and accommodation for any specialized vehicles.

NEED FOR FENCING/BARRIERS

Safety considerations for the injured worker should be considered in determination of whether fencing/barriers should be included in the housing plan. The injured worker may have pets that will require fencing. Negotiation regarding funding of fencing needs to be undertaken during the planning phase of the accessible housing project.

[5] *Archives of Physical Medicine and Rehabilitation* , Volume 86, Issue 5, May 2005.

UNIVERSAL DESIGN

More of a conceptual approach to accessible housing rather than specific criteria found in the General Accessibility subsection, the theory of universal design is the design of products and environments to be usable by all people, to the greatest extent possible, without adaptation or specialized equipment. It was developed by a group of design advocates at the North Carolina State University, College of Design, Center *for Universal Design*, in Raleigh, North Carolina and incorporates a number of principles:

Equitable Use – The design is useful and marketable to people with diverse abilities.

Flexibility in Use – The design accommodates a wide range of individual preferences and abilities.

Simple and Intuitive Use – Use of the design is easy to understand, regardless of the user's experience, knowledge, language skills, or current concentration level.

Perceptible Information – The design communicates necessary information effectively to the user, regardless of ambient conditions or the user's sensory abilities.

Tolerance for Error – The design minimizes hazards and the adverse consequences of accidental or unintended actions.

Low Physical Effort – The design can be used efficiently and comfortably and with a minimum of fatigue.

Size and Space for Approach and Use – Appropriate size and space is provided for approach, reach, manipulation, and use regardless of user's body size, posture, or mobility.

FINANCIAL CONSIDERATIONS

There is no singular solution as to how to address the funding dilemma surrounding the costs for accessible housing. There are as many potential solutions as there are ideas. The solutions are only limited by the creativity of, and negotiation by, the parties to the case. When addressing this aspect of housing, there should be careful attention in regard to the injured employee's present housing status as it is impacted by his/her functional needs and available resources. After the assessment of these needs and availabilities are completed, a course can then be charted to fully address funding for the eventual specific housing needs. Everyone is encouraged to brainstorm the issue and be prepared to compromise.

The employer/insurer must provide accessible, safe housing suitable for the injured worker's post-injury condition. However, there is no requirement anywhere that the employer/insurer must build or buy a house for an injured worker. The injured worker and the employer/insurer both have a responsibility to contribute to the injured worker's suitable housing (Pringle case; see General Considerations, pg. 1, for essence of that decision). An injured worker should not be placed in the position of having to declare bankruptcy because of their need for post-injury accessible housing.

The best practice is to restore the Injured worker as close as possible to their pre-injury state of function. Under the principle of normalization, an injured worker (and his family members who live with him) should not have to pay more that 25 percent of his/their income toward housing costs. Household income should include income of the injured worker and others who reside in the home.

Consideration should be given to additional housing costs beyond the basic rent or mortgage (e.g. taxes, insurance, homeowner association fees, upkeep of yard, maintenance of home, etc.).

Payment for specialists' evaluations required prior to permanent housing decision must be paid by the employer/insurer as part of the housing process.

If an injured worker has equity in a home which is no longer suitable, and the employer/insurer buys or builds a suitable home, the injured worker generally contributes the value of the equity in the pre-injury home toward the new home.

Employer/insurer is responsible for costs of title search, moving expenses, inspections, and closing costs.

Responsibility for payment of fees for any required funding for storage of the injured worker's possessions/equipment is determined on a case by case basis.

Each case involving housing is different, and there is no "one size fits all" resolution. The Rehabilitation Division is available to hold rehabilitation conferences to help parties reach agreements and decisions regarding housing and the financial aspects of suitable housing for injured workers.

PARTIAL STIPULATED SETTLEMENTS FOR HOUSING

The State Board can never force parties to settle all or any part of an injured worker's case. A housing stipulated settlement is considered a partial settlement and resolves only the housing portion of an injured worker's workers' compensation case. It does not affect other benefits or resolve an injured worker's claim in its entirety. Anything parties agree to which is reasonable may be approved. Generally, insurers wish to end all responsibility for housing by agreeing to a stipulated settlement. The employee normally gets a home suitable to their restricted capacity, and the insurer relieves itself of any future responsibility for housing for the injured worker.

GENERAL CONSIDERATIONS

Because housing stipulated settlements usually, permanently resolve all issues relating to housing, the stipulation must spell out quite clearly, exactly what is and what is not covered by the stipulation, including, but not limited to, temporary housing, moving, storage, maintenance of the yard, maintenance of the house, and taxes/insurance.

The Board's Rehabilitation Coordinators are available to hold conferences to discuss possibilities/ramifications of housing stipulations which are being considered by the parties. All housing stipulations must consider end of life issues, as well as what happens if later in the claim the injured worker is medically required to live in a nursing home, rehabilitation facility, or assisted living home as a result of residuals from the injured worker's injury.

ISSUES TO CONSIDER

It is not true that anytime an injured worker settles the housing portion of his case, the employer/insurer pays in full for the building of a new home for the employee, although this may be the case if all parties agree, or an ALJ orders it.

If the injured worker has equity in a pre-injury home which is not suitable for his current medical condition, and parties agree that a new, suitable home will be bought or built, generally the injured worker is expected to contribute the value of the "old" home's equity toward the cost of the new home.

Who holds title to the house is a matter for parties to negotiate.

The possibility of a change in the life circumstances or marital status involving the injured worker, or other major family change, should be addressed in the stipulation. Normally the home

is titled in the name of the injured worker, but if the employee and his/her spouse jointly owned a pre-injury home, that may not be the case.
What happens to the house when the injured worker dies is also a matter of negotiation.
All standard real estate closing procedures must be followed even in cases of stipulated housing settlements.
If there is a probable need for future attendant care, then sufficient space for an attendant should be included in any long-term housing arrangement.
If modifications or building are considered, it is always better to plan for reasonable foreseeable long-range needs so that a one-time renovation or build will be sufficient for the injured worker's lifetime.
Will temporary housing be needed pending the modifications or building? If so, the stipulation should address this issue.
Housing must take into account the family configuration, including pets, children.

Stipulated settlements for housing are not, as of this writing, subject to attorney fees.

ETHICAL CONSIDERATIONS

Certain principles of ethics apply in all healthcare settings. Familiarity Professional Responsibilities of a Rehabilitation Supplier, and the Code of Ethics mandated by the varying underlying certifications required to be registered with the Board, can provide useful guidance in confronting the diverse ethical issues arising in accessible housing. During the process to obtain accessible housing, the Rehabilitation Supplier should be guided by principles of autonomy, beneficence, non-malfeasance, fairness, and veracity.

The Rehabilitation Suppliers have an ethical obligation in working with the catastrophically injured worker to ensure that accessible housing, when needed, is available. In fact, if it is an issue, the Board *requires* that Rehabilitation Suppliers develop an Independent Living Rehabilitation Plan that addresses the housing process. The injured worker's need for reasonable, appropriate accessible housing must be kept as the primary focus. The Rehabilitation Supplier's actions should reflect the role as advocate for the injured worker's safety, function, and accessibility.

Remember, the Rehabilitation Supplier is *not* the housing "expert". The Rehabilitation Supplier's role is the coordination of the consultation of experts and the gathering and dissemination of information of the various options to all parties upon which housing decisions may be made. All parties and the Rehabilitation Supplier have the responsibility to approach and implement the accessible housing process in an ethical manner.

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HOUSING GUIDELINES
ADDENDUM

Stick-Built (Traditional Home)		**Modular Home**	**Manufactured (Mobile) Home**
Foundation, Floors, Walls and Roofing	Concrete block, or poured concrete walls with floors, walls & roofing constructed to meet or exceed local and state building code requirements. Construction occurs on-site.	Same as stick-built with exception that construction includes modules delivered to site and construction is completed on-site, which may include use of crane for placement of modules.	Steel I-beam framing system with wood wall and sub-flooring, all of which is constructed in assembly line in manufacturing plant. Completed product is transported on wheel system to building site. Foundation system may be added but is not necessary.
Accessibility	Accessibility is available through customized construction of doorways, halls, bathrooms, kitchens, floor, etc., including special lighting, sound, and ramping systems.	Accessibility is reported to be available. Customized construction would alter assembly-line production of modules, which will increase costs. Customized construction may not be practical due to additional costs.	Accessibility may be available, but manufacturer will need to be contacted for specific customization needs. Typical manufactured housing is not accessible. Flooring may need to be upgraded.
Codes	Construction will meet local and state building code requirements.	Construction of modules and completion of construction on-site will meet local and state building code requirements.	Construction satisfies H.U.D. building code specifications, which are not equivalent to local or state building codes.
Appreciation and Depreciation	Homes appreciate through approximately 80 years. Depreciation typically begins at 80 years, sometimes earlier, dependent upon quality of construction and materials, as well as frequency of adequate maintenance.		Depreciation occurs more quickly, depending on quality of product. If placed on a masonry foundation, appreciation is possible for many years.
Maintenance	All homes require maintenance. The frequency and expense of maintenance will be dependent upon the original quality of the product and workmanship.		
Garage	Built on-site as part of house, or as a separate garage	Built on-site, either attached to house, or as a separate garage	Built on-site as a separate garage. The manufactured home is not built to withstand the load of an attached garage.
Safety	Built on fixed foundation with quality product	Built on fixed foundation with quality product	Homes may be “tied” to ground through tie-down system.
Longevity	Longevity has a direct relationship to the quality of the original product and associated maintenance over years.		
Cost	Accessibility accommodations will increase the cost of any building system. Researching costs for each specific accessibility modification situation will be necessary.		