LOUISIANA DEPARTMENT OF HEALTH
Aging and Adult Services

# Assistive Devices and Medical Supplies Form (ADMS)

| | | |
|---|---|---|
| **Participant's Name:** | **DOB:** | **Last 4 digits of SSN:** |
| **Address:** | | **Region:** |
| **Responsible Representative** (if applicable): | | |
| **Support Coordination Agency (SCA):** | | |
| **Support Coordinator (SC):** | | **SCA Phone #:** |

*** Assistive Devices (A9999) or Medical Supplies (T2028 SC) exceeding $500 cost must be submitted to Regional Office for Review.**

**I. ADMS Expenses billed by SCA***

| Procedure Code | Item | # of Items Requested | Cost per Item | Total Cost |
|---|---|---|---|---|
| Choose Item | | | | $ 0.00 |
| Choose Item | | | | $ 0.00 |
| | **Totals:** | **----------** | | $ 0.00 |

**II. ADMS Expenses Billed by Assistive Device Provider (Provider Type 17)**

| Procedure Code | Item | # of Items Requested | Cost per Item | Total Cost |
|---|---|---|---|---|
| Choose Item | | | | $ 0.00 |
| Choose Item | | | | $ 0.00 |
| | **Totals:** | **----------** | | $ 0.00 |

**III. Designated Purchaser (DP) Information** (if applicable)

| | |
|---|---|
| **Name:** | **Signature:** |
| **Address:** | |
| **Email:** | **Phone Number:** |

**IV. Final Approval**

By signing, I verify that I have reviewed this form and the item(s) receipts for actual expenditure.

| | | |
|---|---|---|
| **Total Final Cost Authorized:** $ 0.00 | | |
| **SC Signature:** | | **Date:** |
| **SC Supervisor Final Determination Signature:** | | **Date:** |