

Assistive Devices and Medical Supplies Form

Participant's Name: _____ Regional Office (RO): _____

Address: _____

Responsible Representative (if applicable): _____

DOB: _____

Last 4 of SSN: _____

Total Estimated Cost: _____

Total Actual Cost: _____

\$300 maximum total purchase cost for Assistive Device Z0624, with the Support Coordination Agency (SCA) as the billing source.
\$300 maximum total purchase cost for Medical Supply Z0645 with the Support Coordination Agency (SCA) as the billing source.

I. Itemized Assistive Devices and Medical Supplies Expenses

Assistive Device(s) Z0624

Item	Designated Purchaser's (DP) Name	Number of Items Requested	Estimated Cost Completed with Section II	Actual Cost Completed with Section V
Totals:	-----			

Medical Supplies Z0645

Totals:	-----			

II. Pre-Approval Authorization

Pre-Approved Authorization Amount Total for Assistive Device(s) Z0624: _____ (estimated cost total)

Pre-Approved Authorization Amount Total for Medical Supplies Z0625: _____ (estimated cost total)

SC Signature: _____

Date: _____

SC Supervisor Signature: _____

Date: _____

III. Support Coordination Agency

SC: _____
Agency: _____
Address: _____
Phone Number: _____
E-mail Address: _____
SC Signature: _____ Date: _____

IV. Designated Purchaser (DP)

Name: _____
Agency: _____ *if applicable*
Address: _____
Phone Number: _____
E-mail Address: _____
DP Signature: _____ Date: _____

V. Final Approval *completed by the SC Supervisor*

By signing, I verify, as the SC Supervisor, that I have reviewed this form and the item receipt(s) for completeness, compliance and for actual expenditure.

Participant Name: _____
DOB: _____ Last 4 of SSN: _____
Authorization Amount Total for Assistive Device(s) Z0624: _____ (actual cost total)
Authorization Amount Total for Medical Supplies Z0625: _____ (actual cost total)
SC Signature: _____ Date: _____