## Aged/Disable Adult (ADA) Medicaid Waiver
## Specialized Medical Equipment and Supplies (SMES) Request Documentation Form

Consumer Name _____ Date _____ Care Plan Date _____

| Health Condition or Problem | Specific SMES Item to Address Need | Generic Available and Adequate? | Reason Brand Name Product is Necessary | Unit Cost | Quantity Needed | Total Cost per Month | Total Cost | Start Date= Date of this Form<br><br>End Date |
|---|---|---|---|---|---|---|---|---|
| | | Yes _____<br>No _____ | | | | | | |
| | | Yes _____<br>No _____ | | | | | | |
| | | Yes _____<br>No _____ | | | | | | |

☐ I certify that all other options for coverage of the above supplies have been explored and exhausted prior to authorizing the above SMES. These options include the State Medicaid Plan and Medicare.

☐ I have reviewed all the documentation and, in my professional opinion, the need for the above listed SMES in the amount listed is substantiated and the above SMES supplies are essential to enable the recipient to either perform activities of daily living, or stabilize and monitor a health condition.

☐ A medical professional has been consulted to ensure proper SMES is provided to the consumer. Warranty information is on file for equipment and will be maintained in the consumer's file. If available, at least three price quotes were obtained.

_____ _____ _____ _____

Case Manager Signature | Lead Agency | Date | Supervisor's Initial's / Date