



illinicare health™

Adult Day Service Monthly Service Report

Agency: _____

IlliniCare Member Name: _____ DOB: _____

Services Provided (check all that apply):

<input type="checkbox"/>	Eating	<input type="checkbox"/>	Med Administration
<input type="checkbox"/>	Bathing/Dressing	<input type="checkbox"/>	Transferring
<input type="checkbox"/>	Grooming	<input type="checkbox"/>	Telephoning
<input type="checkbox"/>	Continence	<input type="checkbox"/>	Supervision
<input type="checkbox"/>	Meals	<input type="checkbox"/>	Other

Please specify other: _____

Changes in Service plan recommended: Increase hours _____ Decrease hours _____

Reason for Recommendation: _____

Total hours allowed per month: _____ Total hours provided per month: _____

Reason total hours not used: _____

Receive Transportation: _____ YES _____ NO

Please fill in calendar hours per day worked or attach service calendar:

MONTH/YEAR (noted below): _____

1.	2.	3.	4.	5.	6.	7.
8.	9.	10.	11.	12.	13.	14.
15.	16.	17.	18.	19.	20.	21.
22.	23.	24.	25.	26.	27.	28.
29.	30.	31.				

Agency Representative: _____ Date: _____

Please fax this form to 866-975-7387 or email to HCBS@centene.com