



Adult Day Service Monthly Service Report

Agency: _____

MeridianTotal 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 email this form to HCBS@centene.com.