Aetna Better Health® Premier Plan MMAI

Adult Day Service Monthly Service Report

Agency: ____

Illinicare Member Name: ___________________________________ DOB: _____________

Services Provided (check all that apply) :

	Eating		Med Administration
	Bathing/Dressing		Transferring
	Grooming		Telephoning
	Continence		Supervision
	Meals		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 send completed form to members Care Management Representative