ADULT DAY HEALTH CARE
ATTENDING PHYSICIAN STATEMENT

Re: Name of Individual ______________________________
Address ______________________________
City, State, Zip ______________________________
Date of Birth ______________________________
Re: **Adult Day Health Care** ______________________________
Address ______________________________
City, State, Zip ______________________________
Provider # ______________________________

An Adult Day Health Care (ADHC) provider may apply for Level II reimbursement if eighty (80) percent of those individuals receiving services on a "SNAP SHOT" day determined by DMS and based on an average daily census of at least twenty (20) individuals enrolled in the ADHC (limited to: Home and Community Based Waiver clients, private pay or insurance third party liability coverage) and diagnosed as having:

> A disability that manifested itself before the age of twenty – two (22) that is attributable to mental retardation or cerebral palsy, epilepsy, autism or neurological conditions that results, in an impairment of general intellectual functioning or adaptive behavior. This neurological condition should significantly limit the individual in two (2) or more of the following skilled areas: communication, self-care, home-living, social skills, community use, self direction, health and safety, functional academics, leisure, work and limitation similar to that of a person with mental retardation, this limitation should result directly from or is significantly influenced by substantial cognitive deficits. The limitation may not be attributable to only a physical or sensory impairment or mental illness.

The patient **meets** _____ **does not meet** _____ the requirements for **LEVEL II REIMBURSEMENT** according to the above diagnosis definition.

I verify the above statement is true.

Physician's Name (Please Print)
____

Physician's Signature **Date**
____