

## PHYSICIAN EVALUATION For Adult Day Health Care Services

**Division of Health Care Financing and Policy**  
**Home and Community Based**  
**State Plan Services**

Nutritional Needs/Special Diet: ☐ None

1. \_\_\_\_\_

2. \_\_\_\_\_

Allergies: ☐ No ☐ Food ☐ Medication

What: \_\_\_\_\_

History/Physical:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Based on today's exam and review of health history, the following services are ordered: (Please mark all that apply)**

- |  |  |
|--|--|
| <input type="checkbox"/> Nursing Services              | <input type="checkbox"/> Nutritional Assessment and Planning                             |
| <input type="checkbox"/> Care Coordination             | <input type="checkbox"/> Recipient training in activities of daily living                |
| <input type="checkbox"/> Medical supervision           | <input type="checkbox"/> Social and recreational activities                              |
| <input type="checkbox"/> Meals (not full regimen)      | <input type="checkbox"/> Restorative therapy (speech, physical or occupational) and care |
| <input type="checkbox"/> Other (please describe) _____ |  |

**This person is appropriate for Adult Day Health Care Services (ADHC):** ☐ Yes ☐ No

**Why does this patient need ADHC services/Additional Orders?** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**What are the recommended hours/days per week?**

☐ 6 hours/day or more ☐ less than 6 hours/day

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

Physicians Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I, \_\_\_\_\_ hereby authorize my physician  
(Applicant's name)

\_\_\_\_\_ to complete this form and  
(Physician's name)

release necessary medical information to the QIO-like vendor in order to verify program eligibility.

\_\_\_\_\_  
SIGNATURE OF APPLICANT

\_\_\_\_\_  
Date