SOUTHERN ALABAMA REGIONAL COUNCIL ON AGING (SARCOA)
Area Agency on Aging

ACT Medicaid Waiver

Adult Day Health
Voucher Summary Sheet

EXHIBIT I

Contractor: _____

Address: _____

Month: _____ **Year:** _____ **Fiscal Year:** _____

	CONTRACTOR				SARCOA USE ONLY		
SERVICE	**TOTAL RATE PER Day (4+ Hours)**	**TOTAL Units**		**DOLLAR AMOUNT BILLED**	**TOTAL UNIT**		**TOTAL $$$**
		Hours	**Days**		**Hours**	**Days**	
ADH without Transportation	$ 40.93			$			$
ADH with Transportation	$ 50.93			$			$

I REQUEST REIMBURSEMENT FOR SERVICES ADMINISTERED UNDER THE MEDICAID WAIVER PROGRAM. THE SIGNATURE APPEARING BELOW MUST BE ON FILE WITH THE AREA AGENCY ON AGING (SARCOA) AS AN AUTHORIZED SIGNATURE.

_____

ADMINISTRATOR / OFFICIAL DATE