

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

Elderly and Disabled Medicaid Waiver

Adult Day Health
Voucher Summary Sheet

EXHIBIT I

Contractor: _____

Address: _____

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

SERVICE	CONTRACTOR			SARCOA USE ONLY			
	TOTAL RATE PER Day (4+ Hours)	TOTAL UNITS		DOLLAR AMOUNT BILLED	TOTAL UNIT		TOTAL \$\$\$
		HOURS	DAYS		HOURS	DAYS	
ADH without Transportation	\$			\$			\$
ADH with Transportation	\$			\$			\$

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