ADULT DAY HEALTH CARE CENTER
PARTICIPANT INITIAL ASSESSMENT REPORT
COVER SHEET

Instructions to ADHC Centers: Complete this form and attach it to **each** completed Initial Assessment Report before sending to the Long-Term Care Division.

Date: ______________________________

From: ______________________________

To: Department of Health Care Services
Long-Term Care Division
1501 Capitol Ave., MS 0018
PO Box 997413
Sacramento, CA 95899-7413

Please review the attached Initial Assessment Report for the following ADHC participant to determine potential eligibility for the IHO Waiver.

Participant name: ______________________________

Complete Address: ______________________________

10 digit phone #: ______________________________

Date of Birth: ______________________________

Medi-Cal Client ID Number: ______________________________

Please direct questions to:

ADHC Contact: ______________________________

Phone: ______________________________

E-mail: ______________________________

Questions about the IHO Waiver may be directed to the Long-Term Care Division In-Home Operations Branch at (916) 552-9105, or IHOWAIVER@dhcs.ca.gov.

Rev 10/24/11