

FOR-PROFIT MEDICAID PAYMENT SUMMARY FOR ADULT CARE CENTERS

Name: _____ Number (PO...) _____

Site Name: _____ Month/Year: _____

Total Enrollment for the Month: _____

Copies of Medicaid payment documentation must be on file for each participant listed below.

Names of Enrolled Participants Receiving Medicaid Payments for the Month:	Check if Medicaid Payment Documentation is on file	Comments:
1.		
2.		
3.		
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Copies of Medicaid payment documentation must be on file for each participant listed below.

Names of Enrolled Participants Receiving Medicaid Payments for the Month:	Check if Medicaid Payment Documentation is on file	Comments:
26.		
27.		
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