

**DEVELOPMENTAL HOME BILLING STATEMENT**

Developmental Home Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Statement Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Service provided: ADH SERVICE\_\_\_\_\_\_\_\_ ATTENDANT CARE \_\_\_\_\_\_\_ HAB GOALS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RESPITE SERVICE \_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **CONSUMER NAME** | **DAILY RATE** | **TOTAL NUMBER OF DAYS** | **TOTAL AMOUNT** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Were any consumers admitted into the hospital? YES\_\_\_\_ NO\_\_\_\_, who and for how many days?\_\_\_\_\_

Were any consumers taken to Urgent Care? YES \_\_\_\_\_\_NO \_\_\_\_\_, DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

iCare Staff Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***\*BILLING MUST BE SUBMITTED BY THE 5TH OF EACH MONTH TO THE ICARE OFFICE.***

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