



Community-Based Adult Services

1. LICENSEE NAME:		2. HOURS OF SERVICE:	3. LICENSED CAPACITY:	4. ADA for previous quarter:	
5. CENTER NAME:		6. Also Provides Adult Day Program Services? Yes No		7. SIGNATURE OF ADMINISTRATOR OR PROGRAM DIRECTOR: DATE:	
STAFFING	8. NAME	9. Scheduled Number of Hours per Month:	10. Date of Hire:	11. LICENSE/REGISTRATION/CERTIFICATION	
				Number:	Expiration Date:
ADMINISTRATOR					
PROGRAM DIRECTOR					
REGISTERED NURSE(s)					
LICENSED VOCATIONAL NURSE(s)					
SOCIAL WORKER(s)					
SOCIAL WORK ASSISTANT(s)					
ACTIVITY COORDINATOR					
AIDES					
PHYSICAL THERAPIST (PT)					
PT ASSISTANT					
PT AIDE(s)					
OCCUPATIONAL THERAPIST (OT)					
CERTIFIED OT ASSISTANT (COTA)					
OT AIDE(s)					
SPEECH THERAPIST					
STAFF PHYSICIAN					
PSYCH CONSULTANT					
DIETITIAN					
DRIVERS					
PHARMACIST					
OTHER STAFF POSITIONS					