

New Jersey Department of Human Services
Division of Aging Services
Provider Application Section III: Services

ADULT DAY HEALTH SERVICES

*Read carefully the description of services and requirements.
If you do not qualify, please do not apply.*

Definition:

Services furnished 5 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Physical, occupational and speech therapies indicated in the individual's plan of care will be furnished as component parts of this service.

Transportation between the individual's place of residence and the adult day health center will be provided as a component part of adult day health services. The cost of this transportation is included in the rate paid to providers of adult day health services.

Service Limitations/Exclusions Include:

- Meals provided as part of this service shall not constitute a "full nutritional regimen" (3 meals per day).
- Physical, occupational and speech therapies indicated in the individual's plan of care will not be furnished separately from this service.
- Transportation between the individual's place of residence and the adult day health center will be provided as a component part of adult day health services. The cost of this transportation is included in the rate paid to providers of adult day health services.
- Service is limited to 2 days per week in JACC.
- Cannot be combined with Social Adult Day Care.

Billing Codes:

<u>JACC</u>	<u>Service/Unit</u>	<u>Rates Per Unit</u>
J9002	1 day	Variable, not above Medicaid rate

ADULT DAY HEALTH PROVIDER QUALIFICATIONS

The applicant must submit evidence that it meets **all** items within the following section(s).

Please check off **ONE** section in which you are applying
Section 1

Section 1

- 1.a Valid Medicaid provider number for Adult Day Health Services
- 1.b Medicaid Provider # _____
- 1.c Licensed by NJ DOH, per N.J.A.C. 8:43F*

*Submit photocopy as evidence.

**Check all evidence submitted with application.
Incomplete applications and / or applications submitted without required
documentation and evidence will be returned.**

CERTIFICATION

FOR THE PURPOSE OF ESTABLISHING ELIGIBILITY TO RECEIVE DIRECT PAYMENT FOR SERVICES TO RECIPIENTS UNDER THE NEW JERSEY JACC PROGRAM, I CERTIFY THAT THE INFORMATION FURNISHED ON THIS APPLICATION IS TRUE, ACCURATE, AND COMPLETE. I AM AWARE THAT IF ANY OF THE STATEMENTS MADE BY ME IN THIS APPLICATION ARE WILLFULLY FALSE, I AM SUBJECT TO PUNISHMENT, INCLUDING BUT NOT LIMITED TO DISQUALIFICATION FROM THE NEW JERSEY JACC PROGRAM. I AGREE TO NOTIFY THE NEW JERSEY DEPARTMENT OF HUMAN SERVICES, DIVISION OF AGING SERVICES OF ANY CHANGES IN THE INFORMATION CONTAINED IN THIS APPLICATION.

Name and Title of Applicant

Representative _____

Signature _____ Date _____