ADA COUNTY
INDIGENT SERVICES

TREATMENT PLAN

Office (208) 287-7960
Fax (208) 287-7969
252 E. Front Street, Suite 199
Boise ID 83702

PHYSICIANS NAME: _____ Service Worker:_____

RELATING TO THE MEDICAL INDIGENCY APPLICATION FILED WITH ADA COUNTY SERVICES ON: _____

PATIENT:_____ DOB: _____ SSN: _____

- Diagnosis: _____
- **Describe all medical services in the format below. Include information about planned or potential services, diagnostic services (lab, radiology, other), office visits, prescriptions, and any other care, hospitalizations or ambulatory surgical care related to this condition. Be as specific as possible.**
- **ATTACH CHART NOTES, AND RELATED DIAGNOSTIC REPORTS**

TYPE OF SERVICES	PROVIDER	DATES OF SERVICE	COST	PROCEDURE CODE

RE: SURGERY PLEASE INDICATE:

Procedure: _____

Amount of time required to complete procedure: _____

Hospital: _____ **Inpatient:** _____ **Outpatient:** _____ **Length of stay:** _____

Name of assistant surgeon: _____

Pre and/or post op services required (provider): _____

Post-op Physical Therapy Yes ☐ **No** ☐

If yes name of provider _____ **Telephone** _____

Type and length of services _____

Follow up services included in surgical fee: _____

- Were/are the medical services ☐ emergency or ☐ non-emergency?
- Can non-emergency services wait for ten days from (_____)? Yes ☐ No ☐
- Estimate date patient will be released from treatment: _____
- Release date for employment: _____ list any restrictions _____
- Will Patient be able to return to present occupation? Yes ☐ No ☐
- If not, is patient a candidate for Social Security Disability? Yes ☐ No ☐
- and/or Vocational Retraining? Yes ☐ No ☐

Additional comments, including prognosis: (Attach additional sheets or use reverse side if needed.)

_____

_____

_____ _____ _____

Physician's Signature **Date** **Telephone**

Form 15