Print Form

DAILY RECEPTION LOG FOR MEDICAL AND FINANCIAL ASSISTANCE

County: _____ Office Location: _____ Date: _____ Page: _____

Client Name and Address	Applicant (A) Or Representative (R)	Purpose of Visit 1 – Work First App 2 – Medicaid App 3 –See Worker 4 – Other (specify)	Outcome of Visit (Specify)
	☐ A ☐ R		
	☐ A ☐ R		
	☐ A ☐ R		
	☐ A ☐ R		
	☐ A ☐ R		
	☐ A ☐ R		
	☐ A ☐ R		

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