

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)
	<input type="checkbox"/> A <input type="checkbox"/> R		
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