

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

DMA – 5093  
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