



MDC-LARP Monthly Report Sheet

Name: _____

Date: _____

Phone: _____

Email: _____

Note: Only one report sheet should be submitted per month. If you practice at multiple locations, please combine all information on one report.

APRIL – 2016		Hours Worked/Week	# Medicaid Appts/Week SCHEDULED	# Medicaid Appts/Week COMPLETED	Total # Patients/Week
04/01/16	04/02/16				
04/03/16	04/09/16				
04/10/16	04/16/16				
04/17/16	04/23/16				
04/24/16	04/30/16				

Authorized By

Title

Date

PLEASE COMPLETE AND EMAIL BY MAY 10, 2016.

THANK YOU!

EMAIL TO: dhmh.mdclarpprogram@maryland.gov

Please check here to confirm that all information provided is complete and accurate.
Note: This box must be checked for this report to be accepted.