

**NorthCare Network
Substance Abuse Services**

200 W. Spring Street, Marquette, MI 49855

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Monthly Residential Capacity Management Report

FY 2008 – 2009

PROGRAM: _____ **LICENSE # :** _____

DATE: (Please check *Reported** Month)

| | | |
|---|---|--|
| <input type="checkbox"/> October, 2008 | <input type="checkbox"/> February, 2009 | <input type="checkbox"/> June, 2009 |
| <input type="checkbox"/> November, 2008 | <input type="checkbox"/> March, 2009 | <input type="checkbox"/> July, 2009 |
| <input type="checkbox"/> December, 2008 | <input type="checkbox"/> April, 2009 | <input type="checkbox"/> August, 2009 |
| <input type="checkbox"/> January, 2009 | <input type="checkbox"/> May, 2009 | <input type="checkbox"/> September, 2009 |

| <u>Residential:</u> What is your Program's Full Capacity? (Beds Available) | What is your Program's 90% Capacity Mark? (90% of Full Capacity) | Did your Program reach the 90% Capacity Mark (or higher) during Reported Month? | If "Yes", on what Date did your Program first reach the 90% (or Higher) Capacity Mark? |
|---|---|--|---|
| _____ | _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Date: _____ |

Name of Person Completing This Report: _____

***Due Date:** Please FAX this Report *within 15 days of the END of EVERY Reported Month* to:

*Jan McCombie
FAX: 225-7224
Phone: 225-4435*

Note: This form is available in electronic format. Request your copy by emailing: jmccombi@up-pathways.org
(yes, the "e" at the end of my name has been omitted purposely to make my name fit the format! ☺) **Revised 10-2008**