

NorthCare Network Substance Abuse Services

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Monthly Residential Capacity Management Report FY 2011 - 2012

PROGRAM: _____ LICENSE # : _____

DATE: (Please check *Reported** Month)

<input type="checkbox"/> October, 2011	<input type="checkbox"/> February, 2012	<input type="checkbox"/> June, 2012
<input type="checkbox"/> November, 2011	<input type="checkbox"/> March, 2012	<input type="checkbox"/> July, 2012
<input type="checkbox"/> December, 2011	<input type="checkbox"/> April, 2012	<input type="checkbox"/> August, 2012
<input type="checkbox"/> January, 2012	<input type="checkbox"/> May, 2012	<input type="checkbox"/> September, 2012

			From:	To:
Residential: What is your Program's <i>Full Capacity?</i> (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(s) did your Program reach the 90% (or Higher) Capacity Mark during Reported Month. (Use previous month for Start Date, if 90% was "carried over" to this Reported month.)	If "Yes", on what Date(s) did your Program go below the 90% Capacity Mark during Reported Month? (Leave last Date blank, if 90% is "carrying over" to next Report month.)
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____ Date: _____ Date: _____ Date: _____	Date: _____ Date: _____ Date: _____ Date: _____

Name of Person Completing This Report: _____ Date Reported: _____

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

Jan McCombie

Questions? Phone: 225-4435

Note: Please request your Electronic version of this report by emailing: jmccombie@up-pathways.org

Revised 9-2011