

NorthCare Network Substance Abuse Services

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Monthly Residential Capacity Management Report FY 2009 - 2010

PROGRAM: _____ LICENSE # : _____

DATE: (Please check *Reported** Month)

<input type="checkbox"/> October, 2009	<input type="checkbox"/> February, 2010	<input type="checkbox"/> June, 2010
<input type="checkbox"/> November, 2009	<input type="checkbox"/> March, 2010	<input type="checkbox"/> July, 2010
<input type="checkbox"/> December, 2009	<input type="checkbox"/> April, 2010	<input type="checkbox"/> August, 2010
<input type="checkbox"/> January, 2010	<input type="checkbox"/> May, 2010	<input type="checkbox"/> September, 2010

<u>Residential:</u> 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 ?	If "Yes", on what Date(s) did your Program go below the 90% Capacity Mark during Reported Month?
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____ Date: _____ Date: _____	Date: _____ Date: _____ Date: _____

Name of Person Completing This Report: _____

***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 9-2009