



# BLOCK GRANT MONTHLY REPORT

State Form 48203 (R2 / 12-09) / DHHS 0002

Name of Agency		Authorization Number	
Case Manager Name		Consumer Number	
Consumer Name	Date Plan Begins (mm/dd/yyyy)	Date plan ends (mm/dd/yyyy)	

DATE OF INTAKE (MM/DD/YYYY)	INTAKE ISSUES

PLAN OF ACTION(S)	DHHS AUTHORIZATION DATE (MM/DD/YYYY)

REPORT FOR (month / year):					
Date (mm/dd/yyyy)	Beginning Time	Ending Time	Billed Time	Plan Relevant	Services (summary of meeting)

Signature of case manger or ID code	Date (month, day, year)
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