Maryland
DEPARTMENT OF HEALTH

MDC-LARP Monthly Report Sheet

Name: _____   Date: _____

Phone: _____

Email: _____

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

May – 2024		Hour Worked/Week	#Medicaid Appts/Week SCHEDULED	#Medicaid Appts/Week COMPLETED	Total # Patients/Week
05/01/24	05/04/24				
05/05/24	05/11/24				
05/12/24	05/18/24				
05/19/24	05/25/24				
05/26/24	05/31/24				

_____
Authorized By

_____
Title

_____
Date

PLEASE COMPLETE AND EMAIL BY JUNE 10, 2024.

THANK YOU!

EMAIL TO: mdh.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.