ADAMHS
BOARD OF CUYAHOGA COUNTY
ALCOHOL, DRUG ADDICTION & MENTAL HEALTH SERVICES

ACF (RF) CENSUS REPORT

Month:_____ **20**_____

ACF (RF):_____ **License Number:**_____

I certify that all the information listed below is current and accurate to the best of my knowledge.

Operator Name:_____ **# of Vacant Beds:** ____ **# of Total Beds:** ____

Date:_____

Please list all clients receiving RAP funds alphabetically and indicate their current status from the Status Key listed below.

	Client Last Name	Client First Name	Admission DATE	Status Letter(s)	DATE (If applicable)	Status Key
1.						A- No absence during month B- Temporarily absent (dates) C- Whereabouts unknown (date) D- Voluntarily moved out (date) E- Emergency discharge (date) F- Moved after 30 day discharge notice (date) G- Receives SS benefits (date) H- Receives RSS (date) I- Hospitalized (dates) J- Incarcerated (dates) K- Deceased (date)
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						

☐ **Check this box if this facility has no RAP clients this reporting period.**

Submit this Census Report on the 25th day of each month via email to censusreports@adamhscc.org

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