90-120 APPENDIX D. FORM 11-90 HHSA

SUBSTANCE ABUSE SERVICES ORIENTATION SIGN-IN LOG

☐ ENGLISH ☐ SPANISH ☐ OTHER ☐ CHECK HERE IF NO REFERRALS SCHEDULED FOR THIS DATE

FAMILY RESOURCE CENTER: _____ APPOINTMENT DATE: _____ TIME: _____

SIGNATURE	SOCIAL SECURITY NUMBER	COUNTY/RRC USE ONLY						
		CLIENT NAME	CASE NUMBER	INTAKE APPT.	STATUS *	COOP?	COMMENTS	CD/NCD
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								
15.								

***Indicate which program category and if homeless.**
Program Category: TL=Time Limited / IAP=Interim Assistance Program / EL=Employable with Limitations. Include an H, if client is homeless or has no permanent residence.