Division of Health Service Regulation
Mental Health Licensure and Certification Section
Client Census Form

Facility Name: ________________________________________ MHL#: ________________ License Capacity: _______

Survey Date: _____/_____/_____ Surveyor Name:____________________________________________________

| **Current Census of Clients Admitted to Facility** | **Audit** (place check mark beside each audited client's name) | **Medicaid** (Yes or No) | **SA** (Yes or No) | **Home LME** |
|---|---|---|---|---|
| **1.** | | | | |
| **2.** | | | | |
| **3.** | | | | |
| **4.** | | | | |
| **5.** | | | | |
| **6.** | | | | |
| **7.** | | | | |
| **8.** | | | | |
| **9.** | | | | |
| **10.** | | | | |
| **11.** | | | | |
| **12.** | | | | |
| **13.** | | | | |

**Clients Discharged Within the Last 6 Months:**

**1.** ________________________________________________

**2.** ________________________________________________

**Clients Deceased Within the Last 6 Months:**

**1.** ________________________________________________

**2.** ________________________________________________

Client Census/Audit Form (Back Page)

| Current Employee/Staff | Shift | Date of Hire | Current Phone Number |
|---|---|---|---|
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| **Former Employee/Staff** | **Shift** | **Date of Separation** | **Current Phone Number** |
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