

## LOUISIANA'S MEDICAID PROGRAM LOG OF REFERRALS

APPLICATION CENTER NAME: \_\_\_\_\_

APPLICATION CENTER ID #: \_\_\_\_\_ MONTH/YEAR: \_\_\_\_\_

APPLICANT'S NAME TELEPHONE NUMBER	INITIAL CONTACT DATE WITH APPLICANT	REFERRED TO: (Agency or Organization & Date Referred)	AC REPRESENTATIVE MAKING THE REFERRAL
1			
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