Client Name:
Provider Number:
Date Completed:

SIGNATURE PAGE

CLIENT ACTIVE PARTICIPATION STATEMENT: I/We (client/guardian) have actively participated in the development of this service plan and understand the treatment goals and objectives listed. I have the following comments/response:

_____

_____

_____ _____

Member Signature, 14 or older Date Parent/Guardian Signature Date

If unable to legibly sign, document reason: _____

LBHP Signature indicates completion of the face to face assessment to determine medical necessity and appropriate level of care including the evaluation of all pertinent information by the other service practitioners and the member, and a review of the current service plan:

_____

Responsible LBHP Signature, Degree/License/Under Supervision Date

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TREATMENT TEAM:

Type of Service	Treatment Methodology	Frequency of Service(Wk/Mth/Yr)	Lead Staff/Credentials
Individual Therapy			
Interactive Therapy			
Group Therapy			
Family Therapy			
Rehab-Group			
Rehab-Individual			
Psych Test			
Med Trng/Support			
Case Management			
Beh Health Aide			
Community Recovery Support			
Pharmacological (Med) Mgmt			
Other			