YOUTH AND FAMILY
Resource Center
Hope by another name

Treatment Plan Signature Page

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

_____
_____
_____

I/We (__ AGREE) (__ DISAGREE) with this service plan.

I/We have reviewed the Treatment Advocate Form with my/our provider, and based on this review I/We choose (__ NOT TO) (__ TO) change the Treatment Advocate Form.

_____ _____ _____ _____
Client Signature Date Parent/Guardian Signature Date

_____ _____ _____
Witness Signature Date Relationship To Client

If the client is unable to sign, explain: _____

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 client, as well as a review of the current service plan.

_____ _____ _____ _____
Responsible LBHP Signature Date Candidate Signature (If Applicable) Date

Client Name:_____ Date of Birth:_____ ID#_____