MH 636A
Revised 2/22/09

CLIENT CARE COORDINATION PLAN

Addendum Page 2A

Objective Number(s) ______	Unlicensed Staff/Title*		Date:
	PhD/PsyD, LCSW, MFT, RN, CNS		Date:
	MD/DO, NP		Date:
	Client		Date:
	Other		Date:

Client was offered a copy of this objective: ☐ Accepted ☐ Declined Staff Initials: Date:

If the required Client/Other's signature is not above, please justify/explain the refusal or unavailability of the Client/Other and the plan for obtaining signature in the future.

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* Requires Co-Signature

Name: **IS#:**

Agency: **Provider #:**

Los Angeles County – Department of Mental Health

Signature Addendum of the CLIENT CARE/COORDINATION PLAN