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 of	fered a copy of this objective: Ac	cepted	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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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:					
	Unlicensed Staff/Title*				Date:
Objective Number(s)	PhD/PsyD, LCSW, MFT, RN, CNS				Date:
	MD/DO, NP				Date:
	Client				Date:
	Other				Date:
Client was of		cepted	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.					
* Requires Co-Signature					
Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited			Name: Agency:	IS#: Provider #:	
without the prior written authorization of the patient/authorized representative to who it pertains upless otherwise permitted by law Los Angeles County – Department of Mental Health					

representative to who it pertains unless otherwise permitted by law.