West Counseling, PLLC

Name: **DOB:** **Medicaid ID #:** **Record #:**

TREATMENT PLAN SIGNATURES / Service Order

I. Consumer:

☑ I confirm and agree with my involvement in the development of this treatment plan. My signature means that I agree with the services/supports to be provided.
☑ I understand that I have the choice of service providers and may change service providers at any time, by contacting the person responsible for this treatment plan.

Legally Responsible Person: Self: Yes ☐ No ☐
Person Receiving Services: (Required when person is his/her own legally responsible person)
Signature: ____________________ ✓____________________ Date: ✓ /
(Print Name)

Legally Responsible Person (Required if other than person receiving Services)
Signature: ____________________ ✓____________________ Date: ✓ /
(Print Name)

Relationship to the Individual: ✓____________________

II. PERSON RESPONSIBLE FOR Treatment plan:

Signature: ____________________ ✓____________________ Date: ✓ /
(Person responsible for treatment plan) (Name of provider)

Child Mental Health Services Only:

For individuals who are less than 21 years of age (less than 18 for State funded services) and who are receiving or in need of enhanced services and who are actively involved with the Department of Juvenile Justice and Delinquency Prevention or the adult criminal court system, the person responsible for the treatment plan attest that he or she has completed the following requirements as specified below:

☐ Met with the Child and Family Team - Date: ✓ /
☐ **OR** Child and Family Team meeting scheduled for - Date: ✓ /
☐ **OR** Assigned a TASC Care Manager - Date: ✓ /
☐ **AND** conferred with the clinical staff of the applicable LME to conduct care coordination.

If the statements above do not apply, please check the box below and then sign as the Person Responsible for treatment plan:
☐ This child is not actively involved with the Department of Juvenile Justice and Prevention or the adult criminal court system. ✓

Signature: ____________________ ✓____________________ Date: ✓ /
(Person responsible) (Print Name)

II. **SERVICE ORDERS**:

REQUIRED *for all Medicaid funded services;* ***RECOMMENDED*** *for State funded services.*
For services ordered by one of the Medicaid approved licensed signatories (see Instruction Manual).
My signature below confirms the following: (Check all appropriate boxes.)

- Medical necessity for services requested is present, and constitutes the Service Order(s).
- The **licensed professional** who signs this service order has had direct contact with the individual. ☑ Yes ☑ No
- The **licensed professional** who signs this service order has reviewed the individual's assessment. ☑ Yes ☑ No
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Signature: ____________________ ✓____________________ License #: ✓________ Date: ✓ /
(Name/Title Required) (Print Name)

Outpatient counseling to included ___ Individual Counseling ___ Family Counseling __ Grp Counseling (if available)