Western Montana Mental Health Center

YOUTH TREATMENT PLAN SIGNATURE PAGE

Client Name:
Treatment Plan/Treatment Plan Renewal Date:

Signatures

____________________ Client's Signature

____________________ Parent/Guardian Signature

____________________ School Representative

____________________ Additional CSCT Signature

____________________ Outpatient Therapist Signature

____________________ Case Manager Signature

ATTEMPT(S) TO OBTAIN SIGNATURES		
DATE	STAFF INITIALS	ACTION TAKEN TO COLLECT SIGNATURE