Did you receive a copy of your Individualized Plan of Service? Case #________________

☐ Yes, I received a copy. Date Received: ______________________
☐ No, I **do not** want a copy. ______
(initial please)

Did you receive a copy of your Notice of Hearing Rights?

☐ Yes, I received a copy. Date Received: ______________________

Signatures

The signatures below indicate knowledge and agreement with goals, interventions, services, strategies, outcomes, frequency, and responsible person designated in this plan. This plan will be reviewed at least quarterly.

____ ________________
STAFF SIGNATURE/CREDENTIALS DATE

____________________ ____________________ ____________________
CONSUMER SIGNATURE PRINTED NAME DATE

____________________ ____________________ ____________________
PARENT/GUARDIAN SIGNATURE PRINTED NAME DATE

____ ________________
STAFF SIGNATURE/CREDENTIALS DATE

____ ________________
PHYSICIAN SIGNATURE/CREDENTIALS DATE

____ ________________
ACT PSYCHATIATRIST SIGNATURE/CREDENTIALS DATE

____ ________________
RESIDENTIAL PROVIDER SIGNATURE/CREDENTIALS DATE

____ ________________
OTHER STAFF SIGNATURE/CREDENTIALS DATE

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OTHER STAFF SIGNATURE/CREDENTIALS DATE