Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medical Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Card Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CAFAS Treatment Plan Signature Page**

# TEAM MEMBERS’ SIGNATURES

I agree with the treatment plan and have been made aware of my right to Freedom of Choice among sub-providers authorized to provide each service on the treatment plan.

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Parent/Legal guardian/Caregiver ( if child is under 18) Date Client Date

As a team member, I understand that I am to keep all information shared about the child confidential.

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­Behavioral Health Professional (Required) Agency NPI # Date

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Supervisor Signature & Credentials Agency NPI # Date

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Targeted Case Manager (Required) Agency NPI # Date

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Supervisor Signature & Credentials Agency NPI # Date

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Other Agency Date

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Other Agency Date

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Other Agency Date