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James L. Kaufman, LCSW-R, *President and CEO*

Consent for Children and Family Treatment and Support Services (CFTSS)

Child's Name (Last, First, MI):			
Date of Birth:	Sex: ☐ Male ☐ Female	Medicaid CIN #:	Date of Appointment:

It has been explained to me that the child named has been referred for services and if eligible may receive one or more of the following Children and Family Treatment and Support Services:

- ☐ Other Licensed Practitioner-Medical Necessity
- ☐ Other Licensed Practitioner-Evaluation/Assessment
- ☐ Other Licensed Practitioner-Treatment Planning
- ☐ Other Licensed Practitioner-Psychotherapy
- ☐ Other Licensed Practitioner-Crisis Interventions
- ☐ Community Psychiatric Supports and Treatment
- ☐ Psychosocial Rehabilitation

I have read and understand the Children and Family Treatment and Support Services FAQ sheet. I understand how these services can help this child. I also understand that this child's health information may be shared with physicians, psychologists, school personnel or others who are members of the child's care team.

I know that I can change my mind and withdraw my consent for these services at any time.

By signing below, I authorize assessment and/or treatment for the child named above. I also authorize the sharing of information with members of the care team including; pediatrician, psychologist, service providers, hospital (if applicable) and school personnel directly involved with the well-being of the child. My signature confirms my understanding and consent to the Children and Family Treatment and Support Services.

Medical Consenter name:	Medical Consenter Signature:	Date: