

# United American Indian Involvement, Inc.

1125 West Sixth Street, Suite 103 Los Angeles, CA 90017 (213)202-3970 Fax (213)202-3977

## INFORMED CONSENT AND DISCLOSURE OF SERVICES

I understand that the services provided by the United American Indian Involvement, Inc. (UAI) include direct services as well as referral and linkage services.

### UAI PROVIDES THE FOLLOWING SERVICES AS APPROPRIATE TO EACH CLIENT:

- ◆ Substance Use/Abuse Services
- ◆ Case Management Services
- ◆ Employment Services
- ◆ Social Services (Housing, Nutrition, Transportation)
- ◆ Senior Activities
- ◆ Cultural/Spiritual Activities
- ◆ Medical Services
- ◆ Benefits Coordination
- ◆ Mental Health Services
- ◆ Referral to Medical Services
- ◆ Referral to Dental Services
- ◆ Referral to Residential Treatment/Detox
- ◆ Referral to Sober Living
- ◆ Referral to Traditional Practitioners

The direct services listed above are provided free of charge to all qualified UAI Clients. UAI staff will work with the clients to secure services and funding available from various resources outside of UAI. Neither UAI nor any UAI programs guarantee payment for services that are referred to an appropriate health or substance abuse treatment provider.

Initials \_\_\_\_\_ I understand that this consent acknowledges my participation in the services provided by UAI & requires the discussion of my health conditions and health needs with a UAI staff member.

Initials \_\_\_\_\_ I authorize UAI staff to provide the necessary or advisable health screening, assessments and evaluations for the purpose of providing direct services and linkage/referral services for:

Myself \_\_\_\_\_ (Print Name)

My Child \_\_\_\_\_ (Print Child's Name)

Initials \_\_\_\_\_ I understand that some or all of my/my child's personal health information may be shared among UAI Professional Staff and outside Service Providers in order to link me/my child to the appropriate services and to provide active case management services.

Initials \_\_\_\_\_ I understand that UAI and any UAI Programs are not responsible for fees to outside service providers unless I obtain a written referral/authorization for payment from my Case Manager prior to service.

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### Patient Release(s) of Information

I, \_\_\_\_\_ hereby authorize UAI to request and receive copies of my/my child's medical/social services and/or employment information for any services that I receive from outside service providers. I understand that this information will be used to update my records and UAI and to provide appropriate Case Management follow-up and referral services. I further understand and agree that requests for specific information regarding HIV/AIDS status and/or treatment, treatment for drug, alcohol or substance abuse and information related to the treatment of mental health, developmental or psychiatric conditions require a separate consent.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

### Release of Information/Assignment of Benefits

UAI has my permission to release information for myself/my child as needed for insurance processing and to release payment to UAI.

I HEREBY AUTHORIZE TREATMENT

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

UAI Staff Witness: \_\_\_\_\_ Date: \_\_\_\_\_

United American Indian Involvement, Inc.

Los Angeles, California

CLIENT REGISTRATION INTAKE FORM

All Information provided is CONFIDENTIAL

UAI Staff Use Only

\_\_\_\_ New \_\_\_\_ Update

HR# \_\_\_\_\_

Important: If client is under the age of 18 years, this form is to be filled out and signed by legal parent or guardian.

Today's Date: \_\_\_\_\_

Client's Full Name: \_\_\_\_\_ Other Name(s) Used: \_\_\_\_\_

Sex: (Circle One) Male Female T/G Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Soc. Sec. # \_\_\_\_-\_\_\_\_-\_\_\_\_

Place of Birth: (City and State) \_\_\_\_\_ Marital Status: \_\_\_\_\_ (i.e. married, single)

Present Address: \_\_\_\_\_  
Street City State Zip Code

Home Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Office: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Other: (\_\_\_\_)\_\_\_\_-\_\_\_\_  
Message or cell phone number?

Do you have internet access? (Circle one) Yes No If yes, where do you access the internet? \_\_\_\_\_

Email Address: \_\_\_\_\_@\_\_\_\_\_.com

When did you move to your current community? \_\_\_\_\_ (i.e. June 1<sup>st</sup>, 1975)

Living Arrangements: (Circle one) Living with Family Homeless In Treatment Other: \_\_\_\_\_

Preferred Method of Contact: (Circle one) Mail Phone E-mail

May we send you generic health messages through e-mail? (Circle one) Yes No

TRIBAL INFORMATION

Tribal Affiliation: \_\_\_\_\_ (Reservation, Rancheria, Native Corp., Public Law Land)

Blood Quantum: \_\_\_\_\_ Enrollment # \_\_\_\_\_ Other Tribes: \_\_\_\_\_  
(i.e. Full 3/4 1/2 1/4 1/8)

PARENT INFORMATION

Mother / Guardian 1: \_\_\_\_\_  
Last Name First Relationship to client

Telephone: (\_\_\_\_)\_\_\_\_-\_\_\_\_ (\_\_\_\_)\_\_\_\_-\_\_\_\_ @\_\_\_\_\_.com  
Cell Phone Alt. Phone Email Address

Father / Guardian 2: \_\_\_\_\_  
Last Name First Relationship to client

Telephone: (\_\_\_\_)\_\_\_\_-\_\_\_\_ (\_\_\_\_)\_\_\_\_-\_\_\_\_ @\_\_\_\_\_.com  
Cell Phone Alt. Phone Email Address

EMERGENCY CONTACT

Name: \_\_\_\_\_  
Last Name First Relationship to client

Address: \_\_\_\_\_  
Street City State Zip Code

Telephone: \_\_\_\_\_  
Home Phone # Work Phone # Mobile Phone #

NEXT OF KIN (NOT LIVING WITH YOU)

Name: \_\_\_\_\_  
Last Name First Relationship to client

Address: \_\_\_\_\_  
Street City State Zip Code

Telephone: \_\_\_\_\_  
Home Phone # Work Phone # Mobile Phone #

Continue on back side



United American Indian Involvement, Inc.

Los Angeles, California

**CLIENT REGISTRATION INTAKE FORM**

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UAI Staff Use Only

\_\_\_\_ New \_\_\_\_ Update

HR# \_\_\_\_\_

**Household:**

Name	Relationship to client	Sex	AI/AN	DOB	Source of Income	Amount Received
1. Client	Self					
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10						
Total # in household _____					Total Household Monthly Income	

**Employment Information:**

Employer	Address	Phone	Employment Status
			Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Self Employed <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/>
Employer (Spouse's info)	Address	Phone	Employment Status
			Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Self Employed <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/>

Employer (If Minor, Father's info)	Address	Phone	Employment Status
			Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Self Employed <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/>
Employer (If Minor, Mother's info)	Address	Phone	Employment Status
			Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Self Employed <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/>

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United American Indian Involvement, Inc.  
Los Angeles, California  
**CLIENT REGISTRATION INTAKE FORM**  
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UAI Staff Use Only  
\_\_\_\_ New \_\_\_\_ Update  
HR# \_\_\_\_\_

**Health Insurance Information:** Do you have medical health insurance? **Yes No**

If **yes**, please indicate type: (Check one or more boxes that apply and provide further insurance information as requested below)

<input type="checkbox"/> <b>Medicare</b> (Circle one)	<input type="checkbox"/> <b>Medi-Cal:</b> _____	<input type="checkbox"/> <b>Family Pact</b>	<input type="checkbox"/> <b>HMO:</b>
_____			
Part A	(i.e. Health Net, Kaiser, Molina, etc)		(i.e. Blue Cross, Blue Shield, Cigna, etc.)
Part B	Is your Medi-Cal Insurer: (circle one)		
Part D	a. Straight Medi-Cal or		
Railroad	b. Under a Managed Care Plan		
<input type="checkbox"/> <b>Kaiser Permanente</b>	<input type="checkbox"/> <b>Private:</b> _____	<input type="checkbox"/> <b>PPO:</b> _____	<input type="checkbox"/> <b>Veteran</b>
	(i.e. Blue Cross, Blue Shield, Cigna, etc.)	(i.e. Blue Cross, Blue Shield, Cigna, etc.)	
Health Insurance ID #: _____	Eligibility Date or Insurance Issue Date: ____/____/____		
Primary Care Provider: _____	(i.e. Dr. Jane Doe, M.D.)	PCP Phone #: ( ) _____-_____	

Are you a veteran? (Circle One) **Yes No** (If yes, Patient Reg. Staff will ask you additional questions)

Primary Language Spoken: \_\_\_\_\_ Other Languages Spoken: \_\_\_\_\_

Do you identify yourself as Hispanic or Latino? (Circle one) **Yes No Unknown Decline to Answer**

Race: (if other than Amer. Indian) \_\_\_\_\_

**My Signature is a statement that the information provided on this form is true and correct**

_____	____/____/____	_____	____/____/____
Client Signature or Parent / Legal Guardian	Date	UAI Staff Initials	Date

## Client's Bill of Rights and Responsibilities

**The client has the right to receive services and to exercise the following rights without regard to gender, culture, ethnic group identification, economic status, education level, disability, age, creed, religion or sexual orientation. This statement shall not preclude United American Indian Involvement, Inc. (UAI) from emphasizing services for the American Indian/Alaska Native (AI/AN) community:**

- ❖ The client has the right to receive considerate and respectful care and to be accorded dignity in contact with staff, volunteers, board members, and other persons.
- ❖ The client has the right to be free from verbal, emotional, physical abuse and/or inappropriate sexual behavior.
- ❖ The client has the right to expect that all communications and records pertaining to his/her care be treated as **confidential** except in cases of threat to self or others, child abuse, elder or dependent adult abuse or court order. The client's written permission shall be obtained before their records can be made available to anyone not directly concerned with their care. UAI shall assure confidentiality in accordance with Title 42, Code of Federal Regulations, Part 2.
- ❖ The client has the right to know the name of the provider who has primary responsibility for coordinating their care and the names and professional relationships of other providers who will see them.
- ❖ The client has the right to obtain complete and current information concerning their diagnosis, treatment, and prognosis in terms that the client can be reasonably expected to understand.
- ❖ The client has the right to participate in decisions regarding their care unless the health or safety of self or others is being compromised or the client is in an altered state.
- ❖ The client has the right to refuse treatment to the extent permitted by law, and to be informed of the health care consequences of the action.
- ❖ The client has the right to be accorded access to his or her file.
- ❖ The client has the right to leave the premises even against the advice of their providers.
- ❖ The client has the right to expect that UAI will make reasonable response to all requests for services and provide clear explanations for any services that cannot be provided.
- ❖ The client has the right to expect reasonable continuity of care and to know in advance the time and location of appointments.
- ❖ The client has the right to know what the program rules and regulations are that apply to his/her participation in the program.
- ❖ The client has the right to be advised if the provider proposes to engage in research or perform experimentation that in any way affects their care. The Client has the Right to Refuse participation in Experimental Research.

- ❖ The client has the right to be accorded safe, healthful and comfortable accommodations to meet his or her needs.
- ❖ The client's rights will be extended to and apply to any person who is identified to have legal responsibility to make decisions regarding the care of the client.
- ❖ The client has the right to appeal a discharge or file a complaint with the Program Director according to the grievance procedure\*.

**CLIENTS HAVE THE RESPONSIBILITY TO:**

- ❖ Provide accurate and complete information concerning your health history, financial status and/or any other information that is required by UAII in order to provide services.
- ❖ Inform UAII and/or referring facilities if you are not able to keep any appointments 24 hours prior to the scheduled appointment.
- ❖ Request further information concerning anything you do not understand.
- ❖ Speak with the Program Director if you are having difficulty with any staff member.
- ❖ Treat the staff and other clients in a respectful and courteous manner.
- ❖ Follow all rules and guidelines for program participation and use of the UAII facilities.

**UAII HAS THE RIGHT TO:**

- ❖ Refuse service to any client who is verbally or physically abusive or threatening to any staff member or other client (on the phone or in person).
- ❖ Refuse service to any client who is under the influence of alcohol, drugs or other substance.
- ❖ Suspend or terminate services of any client who does not comply with the guidelines or rules that are outlined for use of UAII programs or facilities.

**I have reviewed the Client's Bill of Rights and Responsibilities and understand what my rights and responsibilities are as described above. Furthermore, I understand that I may file a grievance using UAII procedures\* if I feel these rights have been violated.**

Print name of Client \_\_\_\_\_

Signature of Client \_\_\_\_\_

Date \_\_\_\_\_

Signature of UAII Staff \_\_\_\_\_

Date \_\_\_\_\_

**\* The Grievance Policy and Consumer Complaint/Grievance Forms are available at the front desk upon request.**

# United American Indian Involvement

## Acknowledgment declaring awareness of 2013 Notice of Privacy Practices

I hereby acknowledge that I am aware that UAI has a Notice of Privacy Practices (NPP) which details or summarizes my rights involving my protected health information (PHI). This notice is available to me in both printed and electronic formats. UAI has this notice clearly posted on the walls in all UAI waiting areas; has printed hard copies and is viewable on our website [www.uaii.org](http://www.uaii.org). Copies and a detailed explanation of this notice are available to me upon request.

_____	_____	_____
Print Name of Consumer	Signature	Date
Or		
_____	_____	_____
Print Name of Representative	Representative's Signature	Date



### UAI Staff Only

Did the client request a copy of the NPP?

- Yes**
  - A summary version of NPP (copy)
  - Detailed copy version of NPP (copy)
- No**
  - Patient refused a copy, but a brief explanation of the contents of the NPP was provided and the patient understands how they would be able to obtain a copy.
  - Other: \_\_\_\_\_

_____	_____	_____
UAI Staff (Print)	Staff Signature	Date



# United American Indian Involvement, Inc.

1125 West 6th Street, Suite 103 • Los Angeles, California 90017

Tel: (213) 202-3970 • Fax: (213) 202-3977 • uaii.org



**Robert Sundance Family  
Wellness Center**

1125 West 6th Street  
Suite 103  
Los Angeles, CA 90017  
Tel: (213) 202-3970  
Fax: (213) 975-9255

- Inpatient/Outpatient Alcohol/Drug/Mental Health
- Nutrition
- Senior Services
- Sober Living
- Workforce Development Program

**Los Angeles American  
Indian Health Project**

Tel: (213) 202-3970  
Fax: (213) 202-3977

- Primary Care Health Services
- Health Insurance - Enrollment Assistance
- Public Health and Case Management Services
- Diabetes Management and Prevention
- Nutrition Education

**Los Angeles American  
Indian Clubhouse**

Tel: (213) 202-3976  
Fax: (213) 202-3977

- High School Program
- Prevention Workshops
- Summer Camps
- Camping, hiking, sports
- Field Trips
- Recreational/Social Activities

**Seven Generations Child  
and Family Counseling  
Services/System of Care**

Tel: (213) 241-0979  
Fax: (213) 241-0925  
seven\_generations@hotmail.com

- Child & Family Counseling
- Crisis Interventions/Case Management/Parenting Training
- Domestic Violence & Sexual Assault Counseling
- Child Abuse Treatment Program
- Family Preservation
- Prevention and Aftercare
- Innovations

www.uaii.org

RE: SEX OFFENDERS

For all using UAII services,

We at United American Indian Involvement, Inc. strive to keep a safe environment for everyone, while utilizing our services. Due to the fact that we have a high school at our facility, and that we provide services to children, youth and families, we require any person who is registered as a sex offender to voluntarily disclose their status when present at our facility or when receiving services.

If you are a registered sex offender, please make an appointment to see me with the proper documentation specifying your restrictions, so we can try to accommodate your service needs. Information received will be kept confidential or utilized on a need to know basis for relevant staff members. Disclosures of a sex offender status will not result in a refusal of services. However, the time, place, and manner of providing services may be regulated and scheduled to ensure the safety of UAII employees and other clients.

**If you are a registered sex offender and you are identified through public information such as the Megan's Law Website, and you do not self-report, UAII has the right to refuse service.**

Respectfully,

Jerimy Billy  
Chief Executive Officer

Acknowledged by Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Staff Initials: \_\_\_\_\_

Revised: September 21, 2015



United American Indian Involvement  
Staying Healthy Assessment  
**Senior (65+ years)**

		HRN			CM / Program	
Patient's Name (first & last)			Date of Birth		<input type="checkbox"/> Female <input type="checkbox"/> Male Today's Date	
Person Completing Form (if patient needs help) <input type="checkbox"/> Family Member <input type="checkbox"/> Friend <input type="checkbox"/> Other (specify)					Need help with form? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.</i>					Need interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No	
					<b>Staff Use Only:</b>	
Nutrition						
1	Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	N/A		
2	Do you eat fruits and vegetables every day?	No	Yes	N/A		
3	Do you limit the amount of fried food or fast food that you eat?	No	Yes	N/A		
4	Are you easily able to get enough healthy food?	Yes	No	N/A		
5	Do you drink a soda, juice drink, sports or energy drink most days of the week?	Yes	No	N/A		
6	Do you often eat too much or too little food?	Yes	No	N/A		
7	Do you have difficulty chewing or swallowing?	Yes	No	N/A		
8	Are you concerned about your weight?	Yes	No	N/A		
Physical Activity						
9	Do you exercise or spend time doing activities, such as walking, gardening, or swimming for at least 1/2 hour a day?	Yes	No	N/A		
Safety						
10	Do you feel safe where you live?	Yes	No	N/A		
11	Do you often have trouble keeping track of your medicines?	Yes	No	N/A		
12	Are family members or friends worried about your driving?	Yes	No	N/A		
13	Have you had any car accidents lately?	No	Yes	N/A		
14	Do you sometimes fall and hurt yourself, or is it hard to get up?	No	Yes	N/A		
15	Have you been hit, slapped, kicked, or physically hurt by someone in the past year?	No	Yes	N/A		
16	Do you keep a gun in your house or place where you live?	No	Yes	N/A		
Dental Health						
17	Do you brush and floss your teeth daily?	No	Yes	N/A		
18	When was the last time you had a dental exam? If so, when?	Date:				
Behavioral Health						
19	Do you often feel sad, hopeless, angry, or worried?	No	Yes	N/A		

United American Indian Involvement  
Staying Healthy Assessment  
**Senior (65+ years)**

20	Do you often have trouble sleeping?	No	Yes	N/A		
21	Do you or others think that you are having trouble remembering things?	No	Yes	N/A		
22	Have you ever had suicidal thoughts in the past year?	No	Yes	N/A		
23	Have you ever hurt yourself or attempted suicide?	No	Yes	N/A		
24	Over the past two weeks how often have you been bothered by any of the following problems?					
	A) Do you often have little interest or pleasure in doing anything?	Not at all	Several Days	More than half the days	Nearly Every Day	
	B) Do you often feel down, depressed or hopeless?	Not at all	Several Days	More than half the days	Nearly Every Day	
###	Do you smoke cigarettes / e-cigarettes / vapes or chew tobacco?	No	Yes	N/A	Alcohol, Tobacco, Drug Use	
26	Do friends or family members smoke cigarettes / e-cigarettes or vapes in your house or where you live?	No	Yes	N/A		
27	Please circle the answer that best describes:					
	I am currently being treated for an alcohol or other drug problem.	No	Yes	N/A		
	I was treated in the past for an alcohol or other drug problem	No	Yes	N/A		
	I have never been treated in the past for an alcohol or other drug problem	No	Yes	N/A		
28	In the past year, have you had:					
	<b>(Men)</b> 5 or more alcohol drinks in one day?	No	Yes	N/A		
	<b>(Women)</b> 4 or more alcohol drinks in one day?	No	Yes	N/A		
29	In the past 7 days, what types of drugs or alcohol have you used?					
	Types of Drug/Alcohol:					
	Route of Administration:					
30	How often during the last year have you had feeling of guilt or remorse after drinking or use of drugs?	Never	Monthly	Weekly	Almost Daily	
31	How often during the last year have you felt you should cut down on your drinking or use of drugs?	Never	Monthly	Weekly	Almost Daily	
32	How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Monthly	Weekly	Almost Daily	
33	Has a friend, relative, or other health care worker been concerned about your drinking or use of drugs?	No	Yes	N/A		
34	Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?	No	Yes	N/A		

United American Indian Involvement  
Staying Healthy Assessment  
**Senior (65+ years)**

35	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?		No	Yes	N/A	Sexual Issues
36	Have you or your partner(s) had sex with other people in the past year?		No	Yes	N/A	
37	Have you or your partner(s) had sex without a condom in the past year?		No	Yes	N/A	
38	Have you ever been forced or pressured to have sex?		No	Yes	N/A	Independent Living
39	Do you have someone to help you make decisions about your health and medical care?		No	Yes	N/A	
40	Do you need help bathing, eating, walking, dressing, or using the bathroom?		No	Yes	N/A	
41	Do you have someone to call when you need help in an emergency?		No	Yes	N/A	Other Health Questions
42	What type of diabetes do you have?	Date you were diagnosed:	Type I	Type II	Not Diabetic	
43	In the past year, have you had a dilated eye exam (eye drops in the eye to dilate the pupil)?		No	Yes	N/A	
	Date of last eye exam:	Results:	Normal	Abnormal		
44	In the past year, have you had a foot exam (Foot sensation test aka Filament Test)?		No	Yes	N/A	
	Date of last foot exam:	Results:	Normal	Abnormal		
45	In the past year, have you had an EKG/ECG?		No	Yes	N/A	
	Date of last EKG/ECG exam:	Results:	Normal	Abnormal	Borderline	
46	In the past year, have you had a Flu Shot (Vaccine to prevent Influenza)?		No	Yes	N/A	
	Date:					
47	In the past year, have you had a Pneumovax vaccine (Vaccine to prevent pneumonia)?		No	Yes	N/A	
	Date:					
48	Have you ever had the Hepatitis B series completed?		No	Yes	N/A	
	If yes, what were the dates:					
49	Have you ever had a Tetanus shot in the past 10 years?		No	Yes	N/A	
	Date:					
50	In the past year, have you had a TB (PPD) Test?		No	Yes	N/A	
	Date:		Positive	Negative		
	If positive, have you had a Chest X-Ray?		No	Yes		
	Date:					
51	Do you have any other questions or concerns about your health?		No	Yes	N/A	

United American Indian Involvement  
Staying Healthy Assessment  
**Senior (65+ years)**

	<i>If yes, please describe:</i>			
52	Do you have any medical conditions, surgeries or limitations you would like us to know?	No	Yes	N/A
	<i>If yes, please describe:</i>			

**Client Authorization**

I acknowledge that the information provided is correct regarding my health and behaviors.

Client Name	Signature	Date
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**FOR CARE TEAM USE ONLY**

RD / PHN / Clinic Staff	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered		DV	Alcohol	Depression
<input type="checkbox"/> Nutrition					Negative			
<input type="checkbox"/> Physical Activity					Present			
<input type="checkbox"/> Safety					Past			
<input type="checkbox"/> Dental Health					Refused			
<input type="checkbox"/> Tobacco Exposure					Unable to screen			
Staff initials: _____ Date: _____					Staff initials: _____ Date: _____			
<b>STAFF REVIEW (CM / PHN / CLINIC CARE PROVIDER)</b>								
Comments:					Did you meet with the client? <input type="checkbox"/> Yes <input type="checkbox"/> No			
1st Reviewer Signature			Print Name		Date	If yes, were all the clients needs met at this time? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Comments:					Did you meet with the client? <input type="checkbox"/> Yes <input type="checkbox"/> No			
2nd Reviewer Signature			Print Name		Date	If yes, were all the clients needs met at this time? <input type="checkbox"/> Yes <input type="checkbox"/> No		