RECEIPT OF THERAPEUTIC BEHAVIORAL SERVICES (TBS) AND EARLY PERIODIC SCREENING DIAGNOSIS AND TREATMENT SERVICES (EPSDT) NOTIFICATIONS

DATE: _______________________

CLIENT NAME: _______________________________ CHART #:_____________

TBS AND EPSDT NOTIFICATIONS were given to me.

Name of Recipient: ________________________________________________________

Relationship to Client: ______________________________________________________

Signature: ________________________________________________________________

Date: __________________________

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Name of Clinician or Mental Health personnel: __________________________________

Signature of Mental Health personnel: _________________________________________