VERIFICATION OF TREATMENT ATTENDANCE

To Whom It May Concern:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ was admitted to the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ recovery home on

\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ with funding through the Macomb County Community Mental Health Substance Use Services Department. In order to maintain eligibility for MCCMH-SUD funding, they7 must actively participate in outpatient or intensive outpatient treatment. Please complete the following treatment verification for each session attended.

Date Service (individual/group) Therapist Signature Therapist Name (print)

\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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cc: client chart