NOTICE OF FORM CHANGE NO. 03-222

DATE: March 12, 2004

TO:
County Welfare Director
Supply Clerk / Forms Coordinator

FROM:
Forms Management Unit
(916) 657-1907

☐ Community Care Licensing District Offices
☐ District Attorney
☐ Private and Public Adoption Agencies
☑ Other Foster Care Group Homes

Listed below is information regarding a form change. Only applicable information is shown.

This notice updates your Department of Social Services County Forms Catalog.

FORM NUMBER AND TITLE

SR 2C MHV (1/03) Verification Of Mental health Treatment Services

ORDER UNIT		ESTIMATED PRICE	INITIAL SUPPLY SENT
MASTER ONLY	☑ Free ☐ Sold		☐ Yes ☑ No
☑ New ☐ Revised	DATE OF FORM 1/03	REPLACES	☐ Obsolete

REQUIRED FORM-
☑ No Change Permitted
REQUIRED FORM-
☐ Substitute Permitted With Prior DSS Approval
☐ Recommended Form

UNLESS OTHERWISE SPECIFIED STOCK MAINTAINED AT:
Department of Social Services Warehouse
P.O. Box 980788
West Sacramento, CA 95798-0788

☐ OTHER:

FORMS DISPOSITION AND SPECIAL INSTRUCTIONS

DISPOSITION OF OLD SUPPLY
☐ Use until exhausted
☐ Destroy

USE NEW FORM
☐ When supply available in DSS Warehouse
☑ Use new form effective 1/03

USE FORM IN ACCORDANCE WITH
☐ All County Letter No.
☐ Other (specify)

ADDITIONAL INFORMATION REGARDING FORM CHANGE

Attached is a Reproducible Copy

print form: 8 1/2 x 11, one sided□

□
□
□
□
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□

Check on the Internet to see if forms are available at www.dss.cahwnet.gov.□

□

For camera-ready copies of English forms, please call the Forms Management Unit (FMU) at (916) 657-1907, or by □ electronic mail at: fmudss@dss.ca.gov.□

VERIFICATION OF MENTAL HEALTH TREATMENT SERVICES

Please print in ink or type the requested data

PART I - CHILD INFORMATION

CHILD'S NAME: FIRST	MIDDLE INITIAL	LAST	CHILD'S SOCIAL SECURITY NUMBER:

PART II - MENTAL HEALTH PROFESSIONAL INFORMATION

CLINIC NAME:	MENTAL HEALTH PROFESSIONAL'S NAME:
MENTAL HEALTH PROFESSIONAL'S LICENSE OR REGISTRATION NUMBER:	**LICENSE EXPIRATION DATE:**

Please check your professional level:

☐ Psychiatrist ☐ Psychologist ☐ Licensed Clinical Social Worker

☐ Marriage and Family Therapist ☐ Intern ☐ Other *(Specify)*:_____

Are you providing services under another individual's license number? ☐ **Yes** ☐ **No**

If Yes, please provide the name and license number of the mental health professional:_____

PART III - MENTAL HEALTH SERVICES INFORMATION

DATE(S) OF SERVICE:	TOTAL HOURS OF SERVICE:

TYPE OF SERVICE PROVIDED: ***(CHECK APPLICABLE SERVICES PROVIDED)***

☐ Individual Therapy ☐ Group Therapy ☐ Family Therapy

☐ Psychological Testing ☐ Diagnostic Interview ☐ Medication Evaluation

I certify by my signature that I provided the services listed herein.

MENTAL HEALTH PROFESSIONAL SIGNATURE AND TITLE	DATE