

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

BUS TOKEN AUTHORIZATION

DATE _____

Mental Health Clinic

Authorized Name
(Mental Health Professional)

Payroll Title

_____ bus tokens issued to _____
(Number of Tokens) Client Name

Client address: _____
Street City Client Social Security No.
or MIS No.

To be used for _____
(Brief Explanation)

Authorized Signature
(Mental Health Professional/Case Manager)

ACKNOWLEDGEMENT

I acknowledge receipt of _____ bus tokens.
(number)

Signature of Client Date

Signature of Designated Custodian (or designee) issuing tokens _____