



COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

COMMUNITY OUTREACH SERVICES

CONFIDENTIAL CLIENT INFORMATION CALIFORNIA WELFARE & INSTITUTIONS CODE SEC.5238

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|---|--|---|--------------------------------------|--------------------------------------|--|
| PROVIDER #: | | DATE OF SERVICE: | | RENDERING PROVIDER: | |
| SERVICE RECIPIENT TYPE: | | | | # OF PERSONS CONTACTED: | |
| SERVICE LOCATION INFORMATION ENTER AGENCY SERVICE RECIPIENT AND ACTIVITIY INFORMATION BELOW SERVICE TYPE DESC. | | | | | |
| AGENCY NAME: | | | | AGENCY ADDRESS NUMBER/STREET: | |
| AGENCY CONTACT: | | PHONE #: | | CITY / STATE / ZIP: | |
| PLEASE ENTER CODE TO INDICATE PREDOMINANT ETHNICITY AGE RANGE AND LANGUAGE OF TARGET GROUP | | | | | |
| PRIMARY LANGUAGE: | | ETHNICITY: | If Hispanic, indicate Origin: | | If American Indian/Alaska Native, Indicate Tribe: |
| AGE CATEGORY: | | DURATION: (FMI - Fifteen Min. Increment) | HANDICAP: | | PROGRAM AREA: |
| FUNDING SOURCE: | | | | | |
| SERVICE CODE: | | | | | |
| ADDITIONAL PARTICIPATING STAFF: | | | | | |
| | | | | | |
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CERTIFICATION OF CONSULTANT

I CERTIFY THAT THE ABOVE COMMUNITY OUTREACH SERVICES WERE PROVIDED AS DOCUMENTED.

SIGNATURE: _____

DATE: _____

