Print Form

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

COMMUNITY OUTREACH SERVICES

CONFIDENTIAL CLIENT INFORMATION CALIFORNIA WELFARE & INSTITUTIONS CODE SEC.5238

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:		ADDRESS:
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:			

CERTIFICATION OF CONSULTANT

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

SIGNATURE:_____ DATE: _____

COS Form Fillable v3
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PROGRESS NOTES/FUTURE PLANS/RECOMMENDATIONS

PROGRESS NOTES: (Include presenting problems, goals, content, process and outcome)

FUTURE PLANS/RECOMMENDATIONS: (Include major topics or problem areas to be addressed and any special problems or successful techniques which might be helpful in the future consultation)