



CLINICIAN ATTESTATION

ENROLLEE NAME: _____ DOB: _____

CLINICIAN NAME: _____

AGENCY: _____ DATE COMPLETED: _____

By signing this document, I am verifying that I have made an unconditional effort to ensure this consumer's complete understanding of their mental health entitlements, as defined by State and Federal law. Such information was provided in a format appropriate to the Enrollee's culture/language, age and cognitive abilities.

I have provided this consumer with written copies of, fully explained, and am satisfied they understand the documents related to the following:

- Enrollee Rights,
- Advance Directive Information
- Rights to a Second Opinion
- Grievance procedure

Clinician Signature