VERIFICATION OF TREATMENT ATTENDANCE

To Whom It May Concern:

_____ was admitted to the _____ recovery home on ____/_____/_____ with funding through the Macomb County Community Mental Health Substance Use Services Department. In order to maintain eligibility for MCCMH-SUD funding, they must actively participate in outpatient or intensive outpatient treatment. Please complete the following treatment verification for each session attended.

Date	Service (individual/group)	Therapist Signature	Therapist Name (print)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

cc: client chart