**Treatment Advocate Designation**

As a Client, you have the right to designate an individual of your choice, to include a family member, to be your Treatment Advocate. A Treatment Advocate is someone you choose to participate in treatment and discharge planning with you; this person should be someone who you feel will act in your best interest and who will be supportive of your treatment preferences, goals, and objectives.

If you choose to identify a Treatment Advocate, we will honor your wishes regarding who you choose and regarding how involved you would like your Advocate to be in the treatment services you receive. For example, you may want your Treatment Advocate to only participate in the development of your treatment and discharge plans, or you may want him/her present at every individual session; the choice is yours. Furthermore, when your Treatment Advocate is present, how involved he/she is in that treatment session is your choice as well.

At any time during treatment, if your Advocate is not present, we will provide you with the ability to contact your Advocate by phone.

We will explain the importance of respecting your confidentiality to your Treatment Advocate; no one should know about what you discuss with your treatment provider unless you choose to tell them yourself.

You and your Treatment Advocate, if you choose, will be notified no later than 24 hours in advance of any scheduled treatment planning and/or discharge planning sessions.

During any treatment planning or treatment plan review sessions, your Primary Counselor will review this form with you to allow you the opportunity to make any changes that you would like. However, if you would like to review this form or make any changes to it, you are free to do so at any time; your Primary Counselor will be happy to assist you.

Identifying a Treatment Advocate is your choice; treatment services will not be withheld from you if choose not to identify an Advocate.

\_\_\_\_\_ The above information has been explained to me by my Primary Counselor and I

Initial have decided that I would like to name a Treatment Advocate:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print full name of your Treatment Advocate

In your own words, please describe how you would like your Treatment Advocate to be involved

in your treatment services:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_ I understand that I may change or revoke my Treatment Advocate designation at

Initial any time for any reason.

\_\_\_\_\_ The above information has been explained to me by my Primary Counselor and I

Initial have decided that I do not wish to name a Treatment Advocate. I also understand that I may change my mind at any time and that I can name a Treatment Advocate later.

***Agreement to Serve as Treatment Advocate***

\_\_\_\_\_ The above information has been explained to me by the Primary Counselor

Initial providing treatment services to the Client named herein. I understand the responsibilities entailed in serving as a Treatment Advocate, including confidentiality requirements and the level of involvement requested of me by the Client; I hereby agree to serve as the Treatment Advocate for this Client.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date/Time

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treatment Advocate Signature Date/Time

\*If the Treatment Advocate is not present at the time of designation by the Client, verbal confirmation of agreement to serve as the Treatment Advocate by the named Advocate is permitted. If verbal confirmation is received, indicate date/time of confirmation below. The Treatment Advocate’s signature must be entered as soon as possible.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date/Time of Receipt of Verbal Confirmation

**\*\*A copy of the signed Treatment Advocate Designation Form is to**

**be provided to the Client and the Treatment Advocate.**