San Diego County Behavioral Health Services

Full Service Partnership Agreement
Note: This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPPA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to who it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Client #:	
Client Name:	
Date of Birth:	
Partnership Date:	
Name of Full Service Partner:	

As a member of this Mental Health Plan (MHP) your signature below gives your consent to voluntarily receive Full Service Partnership (FSP) treatment services as provided by (enter FSP name):

By signing below, I agree to work with my Personal Service Coordinator (PSC) to develop my individual service plan. This will be a collaborative relationship to enable me to work with staff to accomplish my goals for recovery. I understand the services available to me may include the Full Spectrum of Community Services necessary to attain the goals identified in my individual service plan. I understand that an FSP level of care is my treatment team's recommendation, and that I have the right to refuse to participate in treatment and I may withdraw my consent and stop participating in FSP level treatment at any time, at which time I may be referred to less intensive outpatient mental health treatment instead.

Client Signature	**Date**

Signature of Partner or Parent/Legal Guardian	**Date**
Printed Name of Partner or Parent/Legal Guardian	

Signature of PSC/Case Manager Supervisor	**Date**
Printed Name of PSC/Case Manager Supervisor & Credentials	