**Fountain of Hope Family Services**

**Adult Treatment Advocate Election  
Consumer Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_**

Document completed at: Assessment Treatment Plan (ISP)

**I have been advised of my right to designate a family member or other concerned individual as a treatment advocate while receiving services at Fountain of Hope Family Services.**

**I decline the election of a Treatment Advocate at this time.**

Client Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I elect the following person(s) as Treatment Advocate:**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Client\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Client\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I approve my Treatment Advocate to be involved as follows:

**FULL INVOLVEMENT**

**or**

**PARTIAL INVOLVEMENT** to include the following:

Treatment Planning Assessment Therapy Sessions

Case Management Other:

Client Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I understand as a Treatment Advocate I will serve in this capacity according to the Client's specifications and will comply with all standards of confidentiality.**

*'• \*

Advocate Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Form/FOHFS/144 (Revised 07/03/2016)