Tennessee Department of Children's Services

Verification of Medical/Mental Health Provider Visit
(for Adoption Assistance)

1. CLIENT IDENTIFYING INFORMATION: ALL FIELDS MUST BE COMPLETED			
Client Last Name:	Client First Name:	Date of Birth:	
Address:	City:	State:	Zip:

2. Date of Most Recent Visit MUST BE COMPLETED BY THE LICENSED TREATING PROFESSIONAL WHO IS PROVIDING THE SERVICES TO THE CLIENT
DATE OF MOST RECENT VISIT/APPOINTMENT?

3. Licensed Provider Information	
Licensed Provider: **PRINT NAME AND CREDENTIALS**	
Licensed Provider: **SIGN:**	**DATE:**
Phone Number of Licensed Provider:	**AGENCY/ORGANIZATION NAME:**

TCA 36-1-205
Whoever knowingly obtains, or attempts to obtain, or aids, or abets any person to obtain, by means of a willfully false statement or representation or by impersonation, or other fraudulent device, any assistance on behalf of a child or other persons pursuant to the Interstate Compact on Adoption and Medical Assistance to which such child or other person is not entitled or assistance greater than such child or other person is entitled, commits a Class E felony.