PerformCARE®

Child/Adolescent Services
Interagency Service Planning Team Sign-In/Concurrence Form

A COPY OF THIS FORM MUST BE GIVEN TO THE PARENT/GUARDIAN/RECIPIENT

Member Last Name		Member First Name	
MAID # (10 Digits)		County Of Eligibility (2 Digits)	
Date Of Meeting			

Dates of Initial Evaluation in which each BHRS was prescribed.

TSS		MT		BSC	

In completing the field "Date that Behavioral Health services were first requested", please fill in the date that you (or someone else with your consent) first asked any BHR (wrap-around) provider, county MH/MR worker or behavioral health managed care plan for assistance in obtaining behavioral health services. Also fill in the name of the agency, county, or MCO that was asked for assistance, the name of the person (maybe you) who asked and that person's relationship to your child.

Date That Behavioral Health Services Were First Requested: _____/_____/_____

To Which County/BH-MCO/Provider:_____

By Whom: _____ Relationship To Member: _____

I Agree That The Above Information Is Correct (Parent/Guardian/Member)

Signature:

_____

Confidential information will be discussed during this interagency meeting. My signature below signifies that I agree that I will not disclose this information without the appropriate written consent of the parent/guardian/member and as permitted by state and federal laws and regulations. I am also indicating whether I agree or disagree with the goals of the treatment plan, recommended services and the plan of care summary developed during this meeting.

Outcome of ISPT Meeting/Team Decision:

_____
_____
_____
_____
_____

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Member Last Name		Member First Name	
MAID # (10 Digits)		County Of Eligibility (2 Digits)	
Date Of Meeting			

*Any disagreement must be explained in a memo that is included in the child/adolescent's record and included with the service authorization request if applicable. Please list all members invited to the ISPT meeting. Include their method of participation and date of signature or input obtained.
Method of Participation Codes: **P=in person S=speakerphone RO=report only (not present, but submitted information) NP=invited but not present (include explanation for absence).

Name (include title or credentials)	Relationship to the child/adolescent	Agency (if applicable)	Phone Number Including area code	agree	disagree*	Method of participation ☐Meeting held ☐Input only	Date of signature or input
			( )				
			( )				
			( )				
			( )				
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			( )				
			( )				
			( )				
			( )				

IMPORTANT INFORMATION

Any complaints and problems associated with access to services should be initially directed to Providers, counties or PerformCare. Complaints and problems not resolved in a timely manner can be directed to the following contacts in the Commonwealth's regional field offices of the Office of Mental Health and Substance Abuse Services.

Regional Field Office	Telephone number
Northeast (Scranton) field office	570-963-4335
Southeast (Norristown) field office	610-313-5844
Central (Harrisburg) field office	717-705-8396
Western (Pittsburgh) field office	412-565-5226