PerformCARE®
8040 Carlson Road
Harrisburg, PA 17112

Member Name: **MAID #:** **Date:**

Purpose of ISPT Meeting: **Initial** ☐ **Continued Stay** ☐

Section 1: Background Information

Member Date of Birth: **Age:**

Family Information:

Please list anyone residing in the home:

Name	Age	Relationship	M=male F=female	PerformCare-funded Services and Provider Name

Address: **Phone #:**

County of MA Eligibility:

☐ **Bedford** ☐ **Cumberland** ☐ **Dauphin** ☐ **Franklin** ☐ **Fulton** ☐ **Lancaster** ☐ **Lebanon** ☐ **Perry** ☐ **Somerset**

Who has physical custody of the Member (including relationship to Member):

Does this person have medical rights for the Member: **Yes** ☐ **No** ☐

Capital Members: 1-888-722-8646 Bedford/Somerset Members: 1-866-773-7891 Franklin/Fulton Members: 1-866-773-7917
Providers: 1-888-700-7370 Fax: 1-888-987-5828

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Member Name: | **MAID #:** | **Date:**

If no, who does have medical rights for this Member (including relationship to Member):

What is that person's address: | **Phone #:**

Involvement with other agencies (check all that apply):

Agency	Staff Name
☐ Children & Youth Services	
☐ Juvenile Probation	
☐ ID Supports Coordinator	
☐ Case Management	

Section 2: Medical/Medication

Primary Care Physician:

Current Medical Concerns:

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Medication Information:

Medication	Prescribing Doctor	Agency

Does the Member take all medication as prescribed: **Yes** ☐ **No** ☐

If not, why:

Section 3: Strengths/Natural Supports

Child/Adolescent Strengths:

Family Strengths:

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Community Support/Natural Support involvement: (boys club, girl scouts, piano lessons, etc.) If none identified, please include a plan for engaging Member in natural supports:

Section 4: School/Educational Information

School Name:

Classroom Placement (check all that apply):

- ☐ **Regular Education**
- ☐ **Learning Support**
- ☐ **Emotional Support**
- ☐ **Partial Hospitalization**
- ☐ **Autistic Support**
- ☐ **Residential placement**
- ☐ **Other**

Does the Member have an IEP: **Yes** ☐ **No** ☐

Does the Member have a 504 Behavior Plan: **Yes** ☐ **No** ☐

Has the Member ever been evaluated by a school psychologist: **Yes** ☐ **No** ☐

If so, when and by whom (if known):

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Section 5: Trauma/Substance Abuse

Trauma History:

Substance Abuse History (Include current use, if applicable):

Has the Member ever received treatment for trauma and/or substance abuse (If yes, please specify below):

Yes ☐ **No** ☐

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Section 6: Clinical Presentation

Current Symptoms and Behaviors (Past 1-3 months)

Behaviors	Setting (i.e. H/C, School)	Frequency, Intensity, Duration

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Member Name: **MAID #:** **Date:**

Progress Since Last ISPT Meeting (N/A if Initial ISPT Meeting):

Most Recent Diagnoses (if applicable):

Barriers to Treatment:

Section 7: Discharge and Aftercare Planning

Proposed Discharge Plan (Including identified discharge resources):

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Section 8: ISPT Team Review of Prescription

ISPT Team in Agreement with Evaluator's Prescription*: **Yes** ☐ **No (If not, explain why below)** ☐

***Checking this box Indicates the ISPT facilitator reviewed with Member/Guardian/Family how all prescribed hours will be fulfilled** ☐

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Member Name: | **MAID #:** | **Date:**

Section 9: Plan for Follow-Up Appointments after ISPT (Initial BHRS ONLY)

Providers – If capacity permits, please schedule a date of service for all recommended Behavioral Health Rehabilitation (BHR) services to occur no later than 14 calendar days from the date of this ISPT meeting. (Note: You will be responsible for cancelling any scheduled sessions with the Member/Family for any BHRS level of care that is denied). A copy of this form must be provided to the family prior to the conclusion of the ISPT meeting.

Member/Parent/Family – Please note, BHRS is individualized and home-based, potentially requiring you/your family to adjust to having new people in your home/school/community and joining your daily activities. Scheduling the next appointment below within 14 calendar days ensures you/your child receive timely services and your ongoing participation will help you/your child maximize the benefits of BHRS.

BHRS Level of Care	Name of Provider	Staff Name/Contact #	Follow-up Appointment After ISPT (Date/Location/Time)
Behavioral Specialist Consultant (BSC)/BSC-ASD			
Mobile Therapist (MT)			
Therapeutic Staff Support – Home/Community			
Therapeutic Staff Support (TSS) – School			

Member Signature (if over 14): _____

Parent/Guardian Signature: _____

Provider Representative Signature: _____

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Member Name: | **MAID #:** | **Date:**

Section 10: BHRS Request to Delay for Provider of Choice (for Initial BHRS only)

Chosen Provider Name: _____

Chosen Provider Site/County: _____

BHRS Services pending:

☐ **BSC** ☐ **BSC-ASD** ☐ **MT** ☐ **TSS**

My signature reflects that I am aware my chosen provider does not currently have availability to render the above noted services to me/my child. While I am free to request a transfer at any time, I am willing to wait until such services are available with this provider at this time.

Member/Parent/Guardian Signature: _____

Printed Name: _____

Date: _____

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Member Name: | **MAID #:** | **Date:**

This form completed by (Name, Credentials):

Meeting Location: