



Child/Adolescent Services

Interagency Service Planning Team Sign-In/Concurrence Form

Meeting Date: _____

Member's Name: _____ MAID#: _____

Member County: Cumberland Dauphin Franklin Fulton Lancaster Lebanon Perry

Confidential information will be discussed during this interagency meeting and my signature below signifies that I agree I will not disclose this information without the appropriate written consent of the Member/Parent/Guardian 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 and recommended services developed during this meeting. Any individual in disagreement with the goals of the treatment plan or recommended services should explain this in a Disagreement Memo, which should be included with the prior authorization request.

| Name (include title or credentials) | Relationship to the Member | Agency (if applicable) | Phone Number | Agree | Disagree | Method of Participation** |
|-------------------------------------|----------------------------|------------------------|--------------|-------|----------|---------------------------|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

**P=in person/A=Audio only/V=Virtual/RO=report only (not present, submitted information)/NP=invited, not present (include reason)

