



Magellan Behavioral Health of Pennsylvania, Inc. Delaware County Interagency (CASSP) Team

Child's Name _____ D.O.B. _____ MA ID # _____

Parent/Guardian(s) _____

Family Address _____

Phone Number _____

Home School District _____ Current School Placement _____

Is child a regular or special education student? _____

Date of Interagency Team Meeting: _____

Primary Case Manager/Agency: _____

Interagency Team Leader/Agency: _____

Interagency (CASSP) Team Members

Family Members Present

Name	Relationship	Phone Number	Invited	Present
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Additional Interagency (CASSP) Team Members

Name/Role	Agency	Phone Number	Invited	Present
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

CASE MANAGER / P50 SHARING OF TEAM LEADERSHIP

Write CM (Case Manager) or P50 to indicate assumption of responsibility.

- _____ Scheduling of evaluations and ensuring appointments are kept
- _____ Ensuring family's receipt of Guide to Interagency (CASSP) Team Meetings
- _____ Sending written notification of Interagency (CASSP) Team Meeting
- _____ Facilitation of Interagency (CASSP) Team Meeting
- _____ Completing and distributing Interagency (CASSP) Team Meeting form
- _____ Contacting team members absent from the meeting, to brief them
- _____ Completing treatment plan with child and family
- _____ Completing paperwork for packet, submitting formal request to Magellan Behavioral Health (Magellan), and notifying Interagency team members of Magellan service decisions (approvals, Impartial Reviews, Impartial Review results, and denials)
- _____ Overseeing implementation and ongoing monitoring of treatment plan
- _____ Notifying Magellan when any approved services are not being provided
- _____ Communicating to team the results of all ITM follow-up
- _____ Accessing community resources (contacting community agencies and natural supports identified during the meeting.)
- _____ Assuming responsibility during a crisis (briefly note nature of specific roles)

CM and P50 will each inform the other of all relevant and important events.

Mental Health Case Manager: _____
Name, Title (ICM, RC, AM)

_____ Agency Phone # Fax #

P50 Representative: _____
Name, Title

_____ Agency Phone # Fax #

INTERAGENCY (CASSP) TEAM MEETING

ATTENDANCE/CONFIDENTIALITY STATEMENT

Child's Name: _____

I acknowledge that in attending the CASSP Meeting on _____
Date

I may obtain confidential information. I agree that I will not disclose this confidential information without the valid written authorization of the parent/guardian and/or the child, when age appropriate or as otherwise permitted by applicable laws and regulations.

I understand that if any information is disclosed from Drug and Alcohol records during this meeting that the confidentiality of such information is governed by Federal Regulation (42 CFR Part 2). The Federal rules prohibit me from making any further disclosure of this information unless disclosure is expressly permitted by written authorization of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

Name	Agency/Relationship	Signature
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
8.	_____	_____
9.	_____	_____
10.	_____	_____
11.	_____	_____
12.	_____	_____

I, _____ (parent/guardian), have received the Family Satisfaction Survey. Date: _____