Attachment 2

INTERAGENCY SERVICE PLANNING TEAM SIGN-IN/CONCURRENCE FORM

A copy of this form must be given to the parent/guardian/recipient

Recipient Last Name:		Recipient First Name:	
Recipient Id Number [10 Digits]		Recipient County of Eligibility [2 numeric code]	
Date of Meeting [MM/DD/YYYY]			

Dates of Initial Evaluation in which each Behavioral Health Rehabilitation Services was Prescribed [MM/DD/YYYY]

TSS:		MT:		BSC:	

DATE THAT BEHAVIORAL HEALTH SERVCIES WERE FIRST RECOMMENDED [MM/DD/YYYY] _____

TO WHICH COUNTY/BH-MCO.PROVIDER:_____

BY WHOM:_____RELATIONSHIP TO RECIPIENT:_____

I AGREE THAT THE ABOVE INFORMATION IS CORRECT [PARENT/GUARDIAN/RECIPIENT] 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/Recipient And As Permitted By State And Federal Laws And Regulations. At The End Of The Meeting I Also Indicated Whether I Agree Or Disagree With The Goals Of The Treatment Plan, Recommended Services, And The Plan Of Care Summary Developed During This Meeting.

Name [Include Title Or Credentials]	Relationship To Child/Adol.	Agency [If Applicable.] And Phone #	Agree	Disagree	Method Of Participation ***

*Any disagreement must be explained in a memo that is included in the child/adolescent's record and included with the Outpatient Services Authorization Request [MA-97] if applicable.

**P= In Person S=Speakerphone RO=Report Only [not present, but submitted information] NP= Invited but not present [include explanation for absence].

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 for that person's relationship to your child.

_____

Any complaints and problems associated with access to services should be initially directed to providers, counties or managed care organizations [if applicable]. 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#	Regional Field Office	Telephone#
Northeast [Scranton] Field Office	570-963-4335	Central [Harrisburg] Field Office	717-705-8396
Southeast [Norristown] Field Office	610-313-5844	Western [Pittsburg] Field Office	412-565-5226

This Pennsylvania state form was previously referred to as Attachment 1.