



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	
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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. 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.

Outcome of ISPT Meeting/Team Decision:

