

# Chester County Intermediate Unit

Student Services Division – Assessment & Clinical Services  
HOME AND COMMUNITY SERVICES

Page 1 of 2

## ENHANCED HEALTH SERVICES SIGNATURE PAGE

Client Name: \_\_\_\_\_ MA ID Number: \_\_\_\_\_

Date of ITM: \_\_\_\_\_

### Behavioral Specialist Consultant

Hours per week \_\_\_\_\_ Assigned Staff \_\_\_\_\_

### Mobile Therapist

Hours per week \_\_\_\_\_ Assigned Staff \_\_\_\_\_

Schedule-day of week/time(s) \_\_\_\_\_

### Therapeutic Staff Support

Hours per week \_\_\_\_\_

Schedule (indicate times) and Assigned Staff(s):

Mon: \_\_\_\_\_

Tue: \_\_\_\_\_

Wed: \_\_\_\_\_

Thurs: \_\_\_\_\_

Fri: \_\_\_\_\_

Sat: \_\_\_\_\_

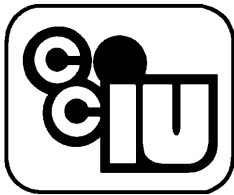
Sun: \_\_\_\_\_

Needs: \_\_\_\_\_

Please indicate any anticipated schedule/staff changes (i.e.: summer break, ESY, etc.)

\_\_\_\_\_

\_\_\_\_\_



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Client Name: \_\_\_\_\_ MA ID #: \_\_\_\_\_

Do you wish for Home and Community Services to find a substitute for any prescribed service (TSS/MT/BSC) if the assigned staff is absent?

TSS: Home/community: Yes \_\_\_\_\_ No \_\_\_\_\_ School: Yes \_\_\_\_\_ No \_\_\_\_\_

Mobile Therapist: Yes \_\_\_\_\_ No \_\_\_\_\_

Behavioral Specialist Consultant: Yes \_\_\_\_\_ No \_\_\_\_\_

Please note, If indicated above that a substitute is not being requested, the BHRS Reason Code will be a “3” (Family offered services as authorized, but requests another staff/provider for reasons not included in the prescription.) instead of a “9” (Staff temporarily unavailable due to reasons such as sickness and vacation). If a substitute staff is requested, H&CS will seek to assign such staff. However, assignment of substitute staff is subject to availability.

### Case Management

Hours per month \_\_\_\_\_ Assigned Staff \_\_\_\_\_

*Total hours are not to exceed the respective authorizations. Hours missed in a week may not be made up in another week. Week starts on Saturday and ends on Friday.*

Issues of note discussed at ITM: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**The Enhanced Health Signature Page is a working document; please notify your Case Manager immediately if any changes occur.**

My signature below indicates that I have participated in the development of this treatment plan. The contents of the plan have been explained to me and I understand it and agree to actively participate in the implementation of the behavioral health interventions. My signature also indicates that I agree to the above staff schedule and number of hours. I agree that the above issues, on pages one and two, were discussed at the ITM.

\_\_\_\_\_  
Child/Adolescent (Print) Signature  
(Required if 14 years of age or older)

\_\_\_\_\_  
Parent/Guardian (Print) Signature