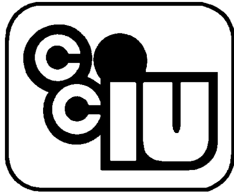

Chester County Intermediate Unit

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

BHRS SERVICES REQUEST

Date: ______________________________ Client Name: ______________________

From: ______________________________ Client S.S. #: ______________________
(Submitting Person)

County of Residence: ________________

____
(Telephone #)

Provider Name: Chester County Intermediate Unit
Provider Phone #: 484-237-5000
Provider Fax #: 484-237-5263

Check ALL that apply to submitted information:

- ☐ EPSDT Residential Treatment Facility
- ☐ EPSDT Therapeutic Foster Care
- ☐ Wraparound /EPSDT Services
- ☐ EPSDT Community Residential Rehab.

Check ALL that apply to submitted information:

- ☐ Initial Packet
- ☐ Reauthorization Packet
- ☐ Packet requesting additional services/change in services
- ☐ Pre-ITM Psychological/Psychiatric Eval
- ☐ Transition Packet

The following is included in an EPSDT packet:

Provider check here:	***Confirmation:***
☐ ITM signature sheet, ITM notes and Confidentiality Statement, Prescriber Collaboration Form	☐
☐ Family Choice Notification Form	☐
☐ Comprehensive Treatment Plan (signed by member, family and provider)	☐
☐ Plan of Care Summary	☐
☐ Comprehensive Psychological / Psychiatric Eval With 5 axis in Life Domain Format [for Wraparound – dated within past 45 days]	☐
☐ MA 97 for all Wraparound services (if applicable)	☐
☐ Performance Outcome Measures System Form (if applicable)	☐