Notification Regarding Implementation of an RTF/IRT/CRR/TFC ISPT Meeting Attendance Request Form

Community Care Behavioral Health is issuing this Alert to inform all RTF/IRT/CRR/TFC providers of the implementation of an Interagency Service Planning Team (ISPT) meeting attendance request form (attached).

- Effective March 1st, 2008 Community Care Behavioral Health will require providers of RTF/IRT/CRR/TFC services to use the attached ISPT meeting attendance request form.
- The form has been developed to allow the provider to include information regarding (but not limited to) the specific type of meeting that will occur, a prompt for active discharge planning to begin no later than 45 days prior to discharge, meeting date, time, and location with direct telephone number for attendees to call in, the facilitator’s name, and the name of the child/adolescent’s home school representative who has been invited to participate in treatment and/or discharge planning.
- **Note:** The form is to be faxed to the respective Community Care Behavioral Health Care Manager at least seven (7) days prior to the scheduled ISPT meeting.

If you have any questions related to this implementation please contact your provider relations representative.
RTF/IRT/TFC/CRR ISPT MEETING ATTENDANCE REQUEST
(Please fax to your Care Manager at least 7 days prior to the scheduled meeting)

Date: ____________________

Attention: __________________________ CCBH Fax: __________________________
          (Care Manager)

From: __________________________ Agency: __________________________

Phone: __________________________ Agency Fax: __________________________

Member’s Name: __________________________ MA#: __________________________

Member’s County of HealthChoices Eligibility: __________________________

An ISPT has been scheduled for the following type of request (check all that apply):

☐ Initial Authorization  ☐ Continued Stay (Reauthorization)
☐ 30 Day (Treatment Review)  ☐ Discharge (ISPT must be at least 45 days prior to D/C date)
☐ Other Explain: __________

The evaluation recommends the following services (please check all that apply):

☐ RTF  ☐ IRT/TFC/CRR  ☐ Other Explain: __________________________

Dates of service to be requested at ISPT: From ______________ Through ______________

Date of Admission: ____________________

ISPT Meeting Date: ____________________ ISPT Meeting Time: ________________

Name of Meeting Facilitator: __________________________

ISPT Location (Include Street Address): __________________________

Telephone Number at ISPT Location: __________________________

Name of Child’s Home School District/IU Representative: __________________________

Home School Representative Invited to ISPT: _____Yes _____No

Please FAX this form to your care manager’s attention at:

<table>
<thead>
<tr>
<th>Community Care Office</th>
<th>Confidential Fax Number</th>
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</thead>
<tbody>
<tr>
<td>Allegheny County</td>
<td>1-888-251-0087</td>
</tr>
<tr>
<td>York, Adams and Berks Counties (Capitol Region)</td>
<td>1-866-418-0366</td>
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<tr>
<td>Chester County</td>
<td>1-888-589-6559</td>
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<tr>
<td>Northeast Region Moosic</td>
<td>1-866-284-9184</td>
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<tr>
<td>North Central Counties DuBois</td>
<td>1-866-294-1142</td>
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<td>North Central Counties Moosic</td>
<td>1-866-558-2618</td>
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<tr>
<td>North Central Counties State College</td>
<td>1-866-562-2406</td>
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<tr>
<td>Carbon, Monroe and Pike Counties</td>
<td>1-866-562-2405</td>
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