TEAM AGREEMENT FORM

Philadelphia Coordinated Health Care
1601 Market Street, 5th Floor
Philadelphia Pa19103
Telephone #215-546-0300/Fax #215-790-4976

Please check one:
- ❑ Pennhurst Class (PH)
- ❑ Embreeville Class (EMB)
- ❑ PH/EMB (Dual Class)
- ❑ Hamburg Center
- ❑ Harry M. Class
- ❑ Jimmie Class
- ❑ Other Class_____
- ❑ Non-Class

Name _____ DOB_____

Address _____

_____Telephone #_____

County of Registration _____

Support Coordinator & Office_____

E-Mail _____

Telephone # _____ Fax # _____

Provider Agency_____ Contact_____

Telephone # _____ Fax # _____

Please check one:
- ❑ Small Community Home/CLA
- ❑ ICF/MR
- ❑ Life Sharing
- ❑ With Family
- ❑ Independent/Supported Living
- ❑ Boarding House
- ❑ Domiciliary Care
- ❑ Nursing Home
- ❑ Private Licensed Facility
- ❑ State Hospital
- ❑ Other
- ❑ N/A

Contact Person for this Request for Services: _____

E-Mail _____Tel # _____ Fax # _____

Provider Agency Nurse _____Telephone #:_____

Provider Agency Nurse Notified re: Situation and PCHC involvement? YES/NO

How Has Agency Nurse Been Involved? (Explain)

_____

For What Health Care Issue(s) Are You Requesting PCHC Assistance *(Explain in detail)?*

PCHC reviews are always undertaken in the context of the whole person, encompassing multiple healthcare needs (physical health, social-emotional well-being, behavioral health, environmental concerns).

_____

_____

_____

Report Recipients *(Please list name and title; include mailing address and e-mail address if not listed above):*

Provider/Family Member: _____
Supports Coordinator: _____
Administrative Entity:_____

Agreement *(Person requesting/requiring assistance, team/family members, and other involved parties such as Behavior Specialist, Psychologist):*

Name *(please print)*	Role	Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Date: _____/_____/_____Referral Mailed or Faxed to PCHC

A Core program of MHCC

Revised 2/14/2020