



TEAM AGREEMENT FORM
Philadelphia Coordinated Health Care Services
 123 S. Broad St., 22nd Floor
 Philadelphia, PA 19109
 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 # _____

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)

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

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

