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| --- | --- |
|  | **MEMBER INFORMATION** |
| **Member Name** | Member Name |
| **Date of Birth** | Date of Birth |
| **MAID#** | MAID# |
| **Parent/Guardian (Name)** | Parent/Guardian Name |
| **Parent/Guardian Contact (Phone)** | Parent/Guardian Contact Phone # |
|  | **MEETING INFORMATION** |
| **Date of Initial ISPT Meeting** | Date of Initial ISPT Meeting |
| **Time of Initial ISPT Meeting** | Time of Initial ISPT Meeting |
| **Location of Initial ISPT Meeting***(include specific street address & zip code)* | Location of Initial ISPT Meeting |
| **Additional Notes** | Additional Notes |
|  | **PROVIDER INFORMATION** |
| **Provider Agency Name** | Provider Agency Name |
| **Provider Agency Contact (Name)** | Provider Agency Contact Name |
| **Provider Agency Contact (Phone)** | Provider Agency Contact Phone # |
| **Provider Agency Contact (Email)** | Provider Agency Contact Email |

**PLEASE NOTE:**

* This form is used to request CBH Clinical Care Management (CCM) attendance at **initial ISPT meetings only**.
* This form must be submitted to CBH at least **five (5) business days** **prior** to the date/time of the scheduled initial ISPT meeting.
* Within 2-3 business days of receiving this form, CBH will notify the identified provider agency contact via phone or email of CBH CCM attendance.

**FORM SUBMISSION INSTRUCTIONS:**

* This form must be submitted through the CBH **secure website** and appropriately labeled as:
**Provider ID#\_MbrMA#\_InitialISPT**.
* Each form must be submitted individually. A provider agency may not submit multiple forms in a batch.