## Letter of Collaboration

R 10-29-13

It is agreed that _______________________________ and ___________________________________
(Facility A) (Facility B)

will collaborate on services provided to ____________________________________________________
(Member's Name)

Recipient ID # ________________________, under the terms identified below, until which time a change is requested. It is also agreed that any changes to the collaboration must be approved by the Member (and/or Guardian when applicable).

This collaboration occurs through two service plans (Facility A service plan and Facility B service plan) developed collaboratively by the facilities' treatment teams. Each facility retains clinical control of and responsibility for its portion of the treatment. The progress in treatment will be coordinated through inter-agency staffing and consultations. The signatures of the respective clinicians below constitute agreement to collaborate *and understanding that if authorizations for services have been issued, they will be modified to reflect this collaboration and service provision will be capped in the system at the agreed upon limits.*

_____________________________________ _____________________________________
Facility A LBHP, Credentials Date Facility B LBHP, Credentials Date

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As the service recipient, I agree to this treatment approach.

______________________________________
Member (14 or older) Date

As the parent/guardian of the above referenced member, I agree to this treatment approach.

____________________________________________________________________________
Parent/Guardian Relationship to Member Date

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Division of the *MONTHLY DOLLAR RATE* as indicated by the CAR/ASI/TASI level is as follows: (in whole dollars)

Facility A:__________ Facility B:__________ Total Dollars:__________

An individual facility’s amount cannot exceed the allowable limit determined by their CAR/ASI/TASI scores, nor can the Total Dollars exceed the allowable limits determined by the higher of either facility’s CAR/ASI/TASI scores.

Services to be provided by each facility:

| | Facility A | Facility B |
|---|---|---|
| Individual Psychotherapy | ☐ | ☐ |
| Group Psychotherapy | ☐ | ☐ |
| Family Psychotherapy | ☐ | ☐ |
| Individual Rehab | ☐ | ☐ |
| Group Rehab | ☐ | ☐ |
| Case Management | ☐ | ☐ |
| Other: __________________ | ☐ | ☐ |

Please note: It is expected that the member will not receive the same type of service at both agencies unless there is a clearly identified and documented clinical need (ex: an individual is receiving group psychotherapy at Facility A for depression, but is also in need of Group Psychotherapy for addiction and Facility A does not have the capacity/expertise to provide it).