<Date>

CP435

<Provider Name>

<Provider Address>

<Provider address>

<Provider address>

Re: <Member Name>

Health Plan I.D. Number: <Health Plan I.D. Number>

Dear <Name of Service Provider contact>:

Please find a copy of the care plan for the member listed above.

Support instructions, if applicable:

The services delivered by your agency will be reviewed and monitored by the Care Coordinator and the member as indicated below.

Once a month

Every 3 months

Every 6 months

Other

Please sign that you have reviewed the plan, acknowledge and agree to provide the services and supports as outlined. Please sign and return within 15 days of the date of this letter. Keep a copy of this letter for your records.

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Provider Signature Date

Sincerely,

<Care Coordinator Name, Title>

<County/Clinic/Organization>

<CC phone number>

<CC fax number or e-mail address>