<Date>

<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 support plan information applicable to your agency for the member listed above.

The services delivered by your agency will be reviewed and monitored by the care coordinator and the member at a minimum of every six months.

Please sign the enclosed signature page, acknowledging that you have reviewed the plan and agree to provide the services and supports as outlined. Please sign and return within 15 days of the date of this letter.

Sincerely,

<Care Coordinator Name>

<Care Coordinator Job Title>

<County or Agency Name>

<Phone Number> | <E-mail Address>