Peer Support & Advocacy Network
Bridging the Gap of Understanding.

960 Penn Avenue
Suite 1100
Pittsburgh PA 15222

Voice: 412-227-0402
Fax: 412-227-0849
www.peer-support.org

Referral Form - Certified Peer Specialist (CPS) Program

This form can be completed by anyone but **MUST be signed and the service authorized by a *Licensed Practitioner of the Healing Arts (LPHA)*; a Physician, Physician's Assistant, Licensed Psychologist, Certified Registered Nurse Practitioner.**

NOTE: To receive certified peer specialist services through PSAN, the individual cannot currently be receiving services that provide or include a certified peer specialist on their team.

I attest that this individual is ***NOT* receiving the following services: ***ACT, CTT, ECSC, Mobile Medications*** *or any services that include a certified peer specialist on their team.*

****Signature_____ Date _____**

PLEASE PRINT OR WRITE LEGIBLY

Participant Name:		Date:
Address:		Phone:
City:	ZIP:	Health Choices Eligible: ☐ Yes ☐ No
DOB:	Social Security #:	MA Recipient #:
Special Residential Status: ☐ N/A ☐ Inpatient/Hospitalized ☐ RTFA Expected Discharge Date: _____ ☐ Homeless		

Person Providing Referral:	Position:
Email:	Phone:
Company/Organization:	
Address:	ZIP:

Current Mental Health Services: (If doctor or therapist only, indicate frequency.)

DIAGNOSES**: Indicate the ICD10 code.** SMI-Serious Mental Illness—A condition experienced by persons 18 years of age and older who, at any time during the past year, had a diagnosable mental, behavioral, or emotional disorder that met the diagnostic criteria and that has resulted in functional impairment and which substantially interferes with or limits one or more major life activities. Adults who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are considered to have serious mental illness. Substance use disorders and developmental disorders are not included.

Code:	Behavioral Health Diagnosis:
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Medical Conditions/Physical Health Issues:	
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MUST meet One of the categories in A, B, or C

A. Treatment History:

☐ Currently resides in SMH or discharged from SMH in the past 2 years
☐ 2 admissions to inpatient psychiatric unit or crisis residential totaling 20 or more days in the past 2 years
☐ 5 or more face to face contacts with walk in, mobile, or emergency services within past 2 years
☐ 1 or more years of continuous attendance in a community mental health or prison psychiatric service within the past 2 years
☐ History of sporadic course of treatment, inability to maintain a medication regimen or involuntary commitment to outpatient services
☐ 1 or more years of mental health treatment provided by a PCP within the past 2 years

B. Coexisting Condition or Circumstance with Mental Illness:

☐ Psychoactive substance use disorder ☐ HIV/AIDS
☐ Intellectual/Developmental Disability Specify:_____
☐ Sensory Disability- Specify: _____
☐ Physical Disability Specify:_____
☐ Homelessness ☐ Release from Criminal detention

C. Involuntary Treatment Status

☐ Met standards for involuntary treatment in the past 12 months preceding this assessment

Category D. (Must Be Indicated)

D. **Must have** a moderate – severe functional impairment that limits performance in 1 of the following:
Check all that apply & provide a brief summary explaining how CPS services can assist with the specified areas of need. Please indicate any other information helpful for service planning.

☐ Educational ☐ Vocational ☐ Social ☐ Self-maintenance

_____
_____
_____
_____
_____
_____
_____

Provide a Current Copy of the Individual's Crisis Plan (within past year)

This form is **valid for 60 days from the date is it signed by a Physician, Physician's Assistant, Licensed Psychologist, Certified Registered Nurse Practitioner.** *The Physician/LPHA has reviewed the referral information, attests to its accuracy, and recommends the above mentioned participant for PSAN's Certified Peer Specialist Program.*

_____

Physician/(LPHA) Signature **Printed Name** **Medical License Number**

_____

Date of LPHA Signature **Telephone Number**

_____

Participant Signature **Printed Name** **Date**

(Please obtain the person's signature whenever possible as it indicates awareness and agreement with the service referral.)

Return this completed form to PSAN, attention CPS Program. Our **secure fax number is 1(888) 972-6489**. Any questions regarding this form or a referral, please contact us at 412-227-0402.