Peer Support & Advocacy Network
Bridging the Gap of Understanding.

PSAN
960 Penn Ave. Suite 1100
Pittsburgh, PA 15222

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 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**

_____

Signature Date **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, please contact us at 412-894-2355.