

**PEER SUPPORT –Referral Form – Ages 14+
CHESTNUT RIDGE COUNSELING SERVICES, INC.**

Client Name: _____ **Age** ____ **DOB** _____

Address
Street _____

City _____ **State** _____

County _____ *(Only Fayette County Residents Eligible)*

Home Phone _____ **Cell Phone** _____ **Alternate No:** _____

Primary DSM Diagnosis & Code:

Plus Functional Deficit Area(s) Checked Below

____ **Ages 14-17** with social, emotional behavioral disorder and one or more functional impairments listed below)

____ **For Ages 18+** - Schizophrenia, Major mood disorders, Psychotic disorder (NOS), Schizoaffective disorder, or Borderline personality disorder qualify for services. **For any other diagnoses**, an attached exception letter should be completed and signed by the LPHA to necessitate Peer Support Services due to a functional impairment in the area(s) marked below.

Check Below 1 or More Functional Areas Necessitating Improvement

| | |
|--------------------------|---|
| <input type="checkbox"/> | Living <i>Independent Living Skills, Cooking, Cost effective Shopping, Money Management, Using public transportation, Linking to Resources and Community Services,)</i> |
| <input type="checkbox"/> | Work/Volunteering <i>finding purpose, improve financial resources, improve supports</i> |
| <input type="checkbox"/> | Educational/Vocational – <i>Improvement in Role Performance</i> |
| <input type="checkbox"/> | Social – <i>(Develop & Use Positive personal and social supports, Development of healthy Relationships, development of natural supports, friendship development, development and linkage with leisure/recreation/hobbies, Communication Skills,)</i> |
| <input type="checkbox"/> | Wellness/Self Maintenance - <i>Life coaching by an Individual who is further along the journey in their own MH Recovery Complete/Update – Wellness Recovery Action Plan (WRAP), Complete MH Advanced Directive, Activities to Increase of Self-Worth, Write and Follow self-designed prevention & wellness process to get well, stay well and make their life the way they want it to be MH Illness education, coping skills, self-advocacy, healthy lifestyle, family relationships, hobbies, follow thru with preventive and ongoing physical health services, quality of life satisfaction exploration and improvement, elimination of barriers, turning weaknesses into strengths,)</i> |

Please explain the functional impairment and needs in each area needing improvement

I am Recommending/Ordering Peer Support Services based on the individual’s Mental Health Diagnosis and the above listed functional improvements needs.

Signature of Ordering/Referring Licensed Practitioner of the Healing Arts

Date

Printed Name: _____ **MD** **DO** **CRNP** **PA**
Licensed Practitioner of the Healing Arts (LPHA) **LCSW** **LPC**

***Signing LPHA must have a Medicaid Promise ID # under their own name**

NPI # _____ **PA Promise ID** _____

If available, Alternate Contact for Referring Practitioner/Organization

Alternate Staff Name _____

Name of Practice/Organization _____

Direct Phone / Ext _____

If Known:

Type of Insurance(s): Beacon Health Options Medicaid, Commercial Ins Medicare
 Non-managed Medicaid Commercially Managed Medicare
 No Current Insurance Coverage

Name of Client’s Primary Insurance _____

Insurance ID # _____

Name of Client’s Secondary Insurance _____

Insurance ID # _____

Fax Completed & Signed Form To: CRCSI – Peer at (724) 437-3221

Any Questions? Call 724-438-5530

**Diagnostic Exception Letter
CRCSI Peer Support Program
1325 Connellsville Rd
Lemont Furnace, PA 15456**

As a Licensed Practitioner of the Healing Arts, I am recommending/referring/ordering the following individual's participation in CRCSI's Peer Support Program even though he/she has a diagnosis other than a severe and persistent mental health diagnosis:

Consumer:

This individual has the following Diagnostic Criteria:

Diagnoses:

Related to the mental health condition, the individual has functional deficits in the following areas:

The individual has a medical necessity and interest to work on skills in the following areas:

Living ___ Working ___ Vocational/Educational ___ Social ___ Wellness/Self Maintenance ___

Skill Building/Support/Goals for the Individual include to become successful and satisfied in the above marked domains are:

Signature of LPHA

Date

Printed Name

Credentials

NPI

MA Promise

Clients are eligible to continue in Outpatient and Community Based Services while enrolled in Peer Support Services