**BERKS COUNTY PEER SUPPORT SERVICES REFERRAL FORM**

**Complete BOTH the Referral and signed Recommendation Forms.**

**Fax to the individual’s SELECTED provider of choice.**

**Agency** **Fax #** **Ages**

* Berks Counseling Center 610-373-3779 14+
* Familicare 610-898-0773 18+
* Greater Reading Mental Health Alliance 610-775-4000 16+
* PeerStar 814-201-2322  14+
* Threshold Rehabilitation Services 855-708-4804 18+

Date of Referral: Referring Agency:

Person Making Referral: Contact #:

Individual’s Name:

DOB: SSN: MA#:

Male / Female Identified Gender: Preferred Gender Pronoun(s):

Primary/Preferred Language: Marital Status: S / M / W / D / Sep

Permanent Address:

Cell Phone: Other Phone:

Current Location/Address/Phone (if different):

Type of Living Situation (i.e. CRR, Independent, PCBH, Shelter, Supported Living, etc.):

Emergency Contact: Relation: Phone:

PCP: Phone:

**Diagnoses**:Behavioral Health (MH & SUD):

Physical Health/Medical Conditions:

Trauma History: Y / N

**Behavioral Health Services**:

Service: Agency: Contact: Phone:

Service: Agency: Contact: Phone:

Service: Agency: Contact: Phone:

Service: Agency: Contact: Phone:

Legal History: Y / N Explain:

Probation/Parole: Y / N Name of Officer: Phone:

Reason for Referral / Goals:

Individual Signature: Date:

Referral Signature: Date:

**BERKS COUNTY PEER SUPPORT SERVICES RECOMMENDATION FORM**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The following document can only be completed by a Licensed Practitioner of the Healing Arts (LPHA)\* acting within the scope of professional practice. This form shall serve as official verification that the individual above fully meets program and medical necessity criteria for receiving Peer Support Services.

**All four** boxes need to be checked in order to qualify for services:

Is fourteen years of age or older.

Has the presence of or a history of a Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED) including diagnosis as defined in the current Diagnostic and Statistical Manual, and functional impairment.

Has a written recommendation for PSS from a LPHA (valid for 60 days), which documents SMI or SED diagnosis and functional impairment resulting from that condition.

Chooses to receive PSS.

Diagnosis(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Printed Name of LPHA

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Signature of LPHA Date

\*Per OMHSAS Bulletin 24-05, a LPHA is (i) A person licensed by the Commonwealth to practice the healing arts. (ii) The term is limited to a physician, physician’s assistant, certified or nurse practitioner, psychologist, licensed clinical social worker, licensed professional counselor, and licensed marriage and family therapist.