**Mental Health Association in Beaver County**

**105 Brighton Ave., Rochester, PA 15074**

**Phone: 724-775-4165 Fax: 724-775-8523**

**Peer Support Services**

**Practitioner Recommendation Form**

Peer Support Services are specialized therapeutic interactions conducted by self-identified current or former participants of behavioral health services who are trained and certified to provide support and assistance in helping others in recovery, age 18 or older, with a Serious Mental Illness.

DIAGNOSES: Indicate the ICD10 code and Diagnosis. **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 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.**

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 Diagnosis Code

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| **MUST meet One of the categories in A, B, or C** |
| 1. **Treatment History:**

**□** 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 the 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 1. **Coexisting Condition or Circumstance with Mental Illness:**

□ Psychoactive substance use disorder□ Intellectual/Developmental Disability- Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_□ Sensory Disability- Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_□ Physical Disability- Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_□ Homelessness1. **Involuntary Treatment Status**

**□** Met standards for involuntary treatment status in the past 12 months preceding this assessment |
| 1**Category D. (MUST BE INDICATED AND EXPLAINED)**1. **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.  □ Living □ Educational □ Vocational □ Social □Self-Maintenance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

This form is valid for 60 days from the date it is signed by a Licensed Practitioner of the Healing Arts.

 **I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,** **recommend**

 **Providers name- Please Print**

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 **Participant’s Name D.O.B.**

for Peer Support Services provided through The Mental Health Association in Beaver County.

 ***\*\*Provider must be must be a Practitioner of the Healing Arts as defined by:***

 **OMHSAS-Provider Handbook for Psychiatric and Partial Hospitalization Services, Section II-Peer Support Service Standards** A: PSS Definitions *LPHA-****Licensed Practitioner of the healing arts*** *(i*)A person licensed by the Commonwealth to practice the healing arts (ii) **The term is limited to a:**

**Physician Certified Registered Nurse Practitioner (CRNP)**

**Psychologist Licensed Clinical Social Worker (LCSW)**

 **Physician Assistant Licensed Professional Counselor (LPC)**

 **Licensed Marriage and Family Therapist (LMFT)**

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 Practitioner’s Signature Date

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