OFFICE OF BEHAVIORAL HEALTH
DELCO CERTIFIED PEER SPECIALIST REFERRAL FORM

PARTICIPANT INFORMATION (Please Print)

Full Name: ____________________ ____________________ ______ Date: ______________
LAST FIRST M.I.

Address: ____ ______________
STREET ADDRESS APARTMENT/UNIT #

_________________________ PA ______________
CITY STATE ZIP CODE

Phone Number: _________________________ Email: ______________________________

Date of Birth: ______________ Social Security No: ______________________ BSU #: ______________
(REQUIRED)

Gender: ______________ Race: ________ Ethnicity (Circle One): Hispanic Non-Hispanic

Insurance: _________________________ MHI#: ______________

INFORMED CONSENT

I have been informed of my rights as a Participant and understand that participation in the Peer Support Services Program is entirely voluntary. I am interested in setting up a meeting to learn more about the program at this time.

Participant Signature: ______________________________ Date: ______________

REFERRAL INFORMATION

Referral Agent: ______________________________ Title: ______________________________

Phone No.: ______________________________ Email: ______________________________

Agency/Program: ______________________________ Reason for Referral: ______________

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DIAGNOSIS

Peer Support Services (PSS) are available to individuals living with a primary diagnosis of Serious Mental Illness or Serious Emotional Disturbance. To receive PSS, a Licensed Practitioner of the Healing Arts (LPHA) must complete a recommendation for the service. An LPHA would include: Physician, Physician's Assistant, Certified Registered Nurse Practitioner, Psychologist, Licensed Clinical Social Worker, Licensed Professional Counselor, and Licensed Marriage and Family Therapist

Provide Primary Mental Health Diagnosis:			
Diagnostic Code, DSM V:		Diagnostic Code, ICD 10:	

If applicable, provide secondary Mental Health Diagnosis or Substance Use Disorder Diagnosis:			
Diagnostic Code, DSM V:		Diagnostic Code, ICD 10:	

Current Functional Impairment (*required: to receive peer support services,* ***MUST CHECK AT LEAST ONE***): This Participant has moderate to severe functional impairment that interferes with or limits performance (relative to the person's ethnic or cultural environment) in at least one of the following domains:

- ☐ Social (e.g., developing a social support system)
- ☐ Self-maintenance (e.g., managing symptoms, understanding his or her illness,
- ☐ Educational (e.g., obtaining a high school or college degree)
- ☐ Vocational (e.g., obtaining part-time or full-time employment)

Comments: ______________________________

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LPHA Name (Print):
Telephone Number:
NPI #:

By signing this form, the Practitioner has reviewed the referral information, attests to its accuracy, and reccomends the above-mentioned Participant for service with Peer Support Program.

Type of Practitioner:

☐ Physician ☐ Physician's Assistant ☐ Licensed Clinical Social Worker

☐ Licensed Psychologist ☐ Certified Registered Nurse Practitioner ☐ Licensed Marriage and Family Therapist

☐ Licensed Professional Counselor

Signature: ______________________ Date: ______________

NON-MA Exception to Diagnostic criteria by OBH: Contact Faith Brown at BrownF@delcohsa.org

MA Exception to Diagnostic criteria by Magellan: Contact Emily Ferris at EFerris@magellan.com

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Exception to Diagnostic Criteria Contact Name ***Date of Contact*** ***Time***

If Referring To Forensic Peer Support, The following MUST be included:

History of Incarceration, if any: ______________ Release Date : ______________

☐ ***Probation*** ☐ Current ☐ Past ☐ ***Parole*** ☐ Current ☐ Past

Probation/Parole Officer: ______________ Phone:

Comments:

Please Select One Peer Support Service

All services are for adults ages 18+ unless otherwise noted. Specialty programming information included.

Peer Support Services Selected

- ☐ Care Link Community Support Services
  Phone (610) 284-1902
- ☐ Child and Family Focus
  Ages 14-26
  Phone (610) 325-3131
- ☐ Child Guidance Resource Center
  Phone (484) 454-8724
- ☐ Crozer Community Hospital
  (including Certified Older Adult Peer Support)
  Phone (610)-619-8716
- ☐ Horizon House Inc.
  Phone (610) 876-6947
- ☐ Merakey of Delaware County
  Phone (610) 534-3636
- ☐ OMNI Health Services
  Phone (267) 308-8136
- ☐ PeerStar, LLC
  (including Forensic and Dual Mental Health and Intellectual Disability)
  Phone (484) 574-8912

Referral Agent Signature: ______________________________ **Date:** ______________________________

Submit completed form to Delaware County OBH via email to Pamela Lucas LucasP@delcohsa.org or (Fax) 610-713-2378 or U.S. mail to: 20 S. 69th Street, 3rd FL, Upper Darby, PA 19082
ATTN: Pamela Lucas