ADULT PEER SUPPORT SERVICES
REFERRAL FORM

Date of Referral:_____

Referring Agency:_____

Person Making Referral:_____Contact #:_____

Complete this form and fax to the agency of the member's choice:

Member must have MA to receive this service

List Other CSP Provider Agencies here

Member Name:_____ DOB:_____ Male / Female

SSN:_____ MA#: _____ Marital Status: S / M / W / D / Sep

Home Address:_____

Home Phone:_____ Cell Phone:_____

Current Location/Address/Phone:_____

_____

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

Emergency Contact:_____ Relation:_____ Phone:_____

Medical Advanced Directive: Y / N Wrap Plan: Y / N

Psychiatric Advanced Directive: Y /N Crisis Plan: Y / N

PCP Practice:_____ MD Name:_____ Phone:_____

Case Management Agency:_____ Case Manager Name:_____ Phone:_____

Outpatient Agency:_____ Therapist Name:_____ Phone:_____

Psychiatrist Agency:_____ MD Name:_____ Phone:_____

Other Behavioral Health Services / Supports:_____

SUD: Y / N Explain:_____

Trauma History: Y / N Explain:_____

Legal (History and Current): Y / N Explain:_____

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

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

NAME:_____ **MA#:**_____

Reason for Referral / Goals:_____

_____

_____

_____

Diagnosis: ***Must include one of the following Behavioral Health SMI Diagnosis: Bipolar Disorder, Borderline Personality Disorder, Major Depressive Disorder, Schizoaffective Disorder, Schizophrenia***

Behavioral Health:

_____

_____

_____

Physical Health/Medical Conditions:

_____

_____

_____

One of the following categories must be met (A, B or C):

A. Treatment History:

- ☐ Currently resides in SMH or discharged from SMH in the past 2 years, or
- ☐ 2 admissions to inpatient psychiatric unit or crisis residential totaling 20 or more days in the past 2 years, or
- ☐ 5 or more face-to-face contacts with walk-in, mobile, or emergency services within the past 2 years, or
- ☐ 1 or more years of continuous attendance in a community mental health or prison psychiatric service within the past 2 years, or
- ☐ History of sporadic course of treatment, inability to maintain med regime, or involuntary commitment to outpatient services, or
- ☐ 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, or
- ☐ Intellectual Disability, or
- ☐ HIV / AIDS, or
- ☐ Sensory Disability (Specify), or
- ☐ Developmental Disability (Specify), or
- ☐ Physical Disability (Specify), or
- ☐ Homelessness, or
- ☐ 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 met:

D. Must have a moderate to severe functional impairment that limits performance in 1 of the following: Explanation of the impairment needs to be provided.

- ☐ Educational _____
- ☐ Social _____
- ☐ Vocational _____
- ☐ Self-maintenance_____

Member Signature:_____ Date:_____

Referral Signature:_____ Date:_____