

**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: _____