SERVICE ACCESS and MANAGEMENT, Inc.
YOUTH/ YOUNG ADULT/ADULT
CERTIFIED PEER SPECIALIST
RECOMMENDATION FORM

Name: _____ DOB: _____

The following document can only be completed by a Psychiatrist, Licensed Psychologist, CRNP, or PA-C. This form shall serve as official verification that the person above fully meets program and medical necessity criteria for receiving Peer Support Services.

Identify age group that applies:		
☐	Is eighteen years of age or older and no longer in an educational system	Adult Peer Service
☐	Is over 14 years of age but under 18 years of age	Youth Peer Service
☐	Is over 18 years of age but under 27 years of age	Young Adult Peer Service
Identify disability that applies:		
☐	Has a documented Serious Emotional Disturbance as defined by: a condition experienced by a person under the age of 18 who currently or at any time during the past year had a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet the diagnostic criteria within the current Diagnostic and Statistical Manual; and that has resulted in a functional impairment which substantially interferes with or limits the child's role of functioning in family, school, or community activities.	
☐	Has a documented Serious Mental Illness (over 18) as defined by: a condition experienced by a person 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 within the current Diagnostic and Statistical Manual; and that has resulted in a functional impairment which substantially interferes with one or more major life activities. Adults who have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are considered to have serious mental illness.	
Specify Diagnosis/es:		
Identify life activities in the following areas which have been substantially impacted by the individual's functional impairment:		
	Area	Provide explanation about impairment
☐	Educational	
☐	Social	
☐	Vocational	
☐	Self-Maintenance	

Printed Name of Physician, Licensed Psychologist, CRNP or PA-C:	
Signature of Physician, Licensed Psychologist, CRNP or PA-C:	
MA Enrollment Promise#:	
NPI #:	
Date:	