

Referral Form - Certified Peer Specialist (CPS) Program

This form can be completed by anyone but MUST be signed and the service authorized by a Licensed Practitioner of the Healing Arts (LPHA), a Physician, Physician's Assistant, Certified Registered Nurse Practitioner, Licensed Psychologist, Licensed Clinical Social Worker, Licensed Professional Counselor, Licensed Marriage, and Family Therapist.

	vices through PSAN, the indicate on their team.			_	•		
	ist on their team. Please in ile Medications or any serv		_		_	au.	
ACT, CTT, ECSC, Mobile Medications or any services that include a certified peer specialist on their team. Initials/Date:							
PLEASE PRINT OR WRITE LEGIBLY							
Participant Name:				Date:			
Address:				Phone:			
City:		ZIP:		Health Choices Eligible: ☐ Yes ☐ No		☐ No	
DOB:	Social Security #:		MA Re	ecipient #:			
Special Residential Status: N/A Inpatient/Hospitalized RTFA Expected Discharge Date: Homeless							
Person Providing Referral: Position:							
Email:				Phone:			
Company/Organization							
Address:				ZIP:			
Current Montal Health Conjects (If destar or therepist only indicate frequency)							
Current Mental Health Services: (If doctor or therapist only, indicate frequency.)							
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.							
Code:	Behavioral Health Diagnosis:						
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Medical Conditions/Ph	nysical Health Issues:						
Medical Conditions/Physical Health Issues:							

MUST meet One of the categories in A, B, or C					
2 admissions to inpatient psychiat 5 or more face to face contacts wi 1 or more years of continuous atte History of sporadic course of treat services 1 or more years of mental health t B. Coexisting Condition or Circums Psychoactive substance use disor Intellectual/Developmental Disabil Sensory Disability- Specify: Physical Disability Specify:		st 2 years rchiatric service within the past 2 years involuntary commitment to outpatient			
C. Involuntary Treatment Status	tment in the past 12 months preceding this assessm	nent			
	Category D. (Must Be Indicated and Explaine functional impairment that limits performance in 1 of summary explaining how CPS services can assist who reservice planning. Vocational Social	the following:			
Provide a C	urrent Copy of the Individual's Crisis Plan (v	within past year)			
Registered Nurse Practitioner, Licens	date is it signed by a Physician, Physician's Assed Clinical Social Worker, Licensed Professional has reviewed the referral information, attests to its accidist Program.	al Counselor, Licensed Marriage, and			
Physician/(LPHA) Signature	Date of LPHA Signature	Medical License Number			
Printed Name of LPHA	Telephone Number				
Participant Signature Please obtain the person's signature when	Date Date nenever possible as it indicates awareness and agree	Participant Name Printed eement with the service referral.)			

Return this completed form to PSAN, attention CPS Program. Our secure fax number is 1(888) 972-6489. Any questions regarding this form or a referral, please contact us at 412-227-0402.