COUNTY OF CHESTER CERTIFIED PEER SPECIALIST (CPS) REFERRAL FORM

Date of Referral: _____

Referral Source Name: _____ **Agency**: _____

Phone Number: _____ **Fax number:** _____

Individual Being Referred: _____

Eligibility Criteria

- Resident of Chester County
- Individual is 14 years of age or older for youth services
- Individual is 18 years of age or older for adult services
- Has the presence or history of a Severe Mental Illness (SMI) OR
- Has the presence or history of a Serious Emotional Disturbance (SED) AND
- Chooses to participate in the program

Individual's Address: _____

DOB: _____ **SSN:** _____

Phone: _____ **Cell Phone:** _____

MA ID#: _____ **Other Insurance:** _____

Current DSM V Diagnosis(es) and Codes:_____

Parent/Guardian's Name (if applicable): _____

Reason for Referral: _____
_____
_____

Is the individual working with a Mental Health Case Manager: ☐ Yes ☐No

<u>Needs to be addressed through Peer Support Services:</u>

1. **Living:** _____
   _____
2. **Educational:** _____
   _____
3. **Vocational:** _____
   _____

4. **Social:** _____
_____

5. **Wellness:** _____
_____

6. **Building Supports:** _____
_____

7. **Resources and Cultural Needs:** _____
_____

Copies of the following should be included in the referral packet. Please check off:

- ☐ A Reciprocal Release of Information form signed by the individual being referred
- ☐ Documentation of Individual's Diagnosis e.g., Psychiatric Evaluation, Discharge Summary etc.
- ☐ Most recent Treatment Plan/Discharge Plan (if applicable)
- ☐ Insurance Verification
- ☐ Recommendation of LPHA

According to the regulations, Peer Support Services must be recommended by a Licensed Practitioner of the Healing Arts (LPHA). **Failure to provide the recommendation will delay the start of services.** LPHA is defined as: a psychiatrist, physician, physician's assistant, certified registered nurse practitioner, psychologist, licensed professional counselor, licensed clinical social worker, or licensed marriage and family therapist.

_____

Signature of Licensed Practitioner/Credentials **Date**

_____

Name of LPHA (Print)

Packets can be faxed to the following providers. Please check the box of each provider the referral is being sent to:

☐ **Child & Family Focus**
11 Davis Rd., Building 2,
Suites 300 and 320
Phoenixville, PA 19460
Tel: (610) 650-7750
Fax: (610) 650-7761
Serving: Ages 14-26

☐ **Creative Health Services**
11 Robinson Street
Pottstown, PA 19464
Tel: (484) 941-0500
Fax: (610) 326-6987
Serving: Adults

☐ **Devereux**
100 Deerfield Ln.
Malvern, PA 19355
Tel: (215) 539-7424
Fax: (610) 933-7451
Serving: Ages 14-18+

☐ **Fellowship Health Resources**
1041 W. Bridge Street, Ste. 5
Phoenixville, PA 19460
Tel: (610) 415-9301 Ext. 2215
Fax: (610) 415-1656
Serving: Adults

☐ **Holcomb Behavioral Health**
467 Creamery Way,
Exton, PA 19341
Tel: (610) 363-1488
Fax: (610) 363-1222
Serving: Adults

☐ **Human Services, Inc.**
50 James Buchanan Drive
Thorndale, PA 19372
Tel: (610) 200-6222
Fax: (610) 873-3317
Serving: Adults

☐ **Penn Psychiatric Center**
601 Gay St. Suite 6
Phoenixville, PA 19460
Tel: (610) 917-2200
Fax: (610) 917-2360
Serving: Youth & Adults