



## Referral Form for Peer Support Services

Please submit all referrals to: [Peersupportservices@projecthome.org](mailto:Peersupportservices@projecthome.org)

Date of Request: \_\_\_\_\_

Participant Name: \_\_\_\_\_ Preferred Pronouns: \_\_\_\_\_

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Participant's Phone #: \_\_\_\_\_ Gender: \_\_\_\_\_ Race: \_\_\_\_\_

Agency Submitting the Request: \_\_\_\_\_

Referral Contact Person: \_\_\_\_\_

Contact Phone #: \_\_\_\_\_ Contact Email: \_\_\_\_\_

Is Participant involved in Permanent Supportive Housing (PSH): yes \_\_\_ no \_\_\_\_\_

Program Type/Type of Residence: \_\_\_\_\_

Current Address:  
\_\_\_\_\_

### Current Supports and Contact Information

Case Management Contact (TCM/PMHCC):  
\_\_\_\_\_

Case Management Supervisor Contact:  
\_\_\_\_\_

Outpatient or Intensive Outpatient:  
\_\_\_\_\_

### Behavioral and Substance Use History

Current/ History of Mental Health (diagnosis, recent hospitalization, suicide attempts):  
\_\_\_\_\_  
\_\_\_\_\_

Current/History of Substance Use (drug choice, duration used amount):  
\_\_\_\_\_  
\_\_\_\_\_

Evidence of Cognitive Impairment:  
\_\_\_\_\_

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Physical Health Concerns:

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Member can benefit from gaining skills in the following areas:

- o Shopping
- o Education
- o Paying bills
- o Caring for medical needs
- o Taking Medication
- o Other: \_\_\_\_\_
- o Self-care
- o Employment Support
- o Assistance with ADL's
- o Community Integration
- o Travel Training

Reason for request:

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Applicant

Signature \_\_\_\_\_

Date \_\_\_\_\_

Referral Source

Signature \_\_\_\_\_

Date \_\_\_\_\_

**Program Contact Information-**

PROGRAM DIRECTOR- Marsha Young, [marshayoung@projecthome.org](mailto:marshayoung@projecthome.org) (215) 232-7272

CPS SUPERVISOR- Deighmion Monroe, [deghmionmonroe@projecthome.org](mailto:deghmionmonroe@projecthome.org) (267) 846-0591

## LPHA Form and Program Eligibility

Project HOME's Peer Support Services program provides peer-led services that encourage individuals to develop resiliency and recovery skills. Participants are matched with a Certified Peer Specialist who can help them identify goals, learn and practice skills, and build support. Peer Support Services are person-centered, strength-based, and aimed at empowering individuals to accomplish their self-identified goals.

### Who can complete this form?

Only someone that is considered a "Licensed Practitioner of the Healing Arts" (LPHA) can complete this form. The following is a list of practitioners that are included in this category.

1. Physician (M.D.)
2. Physician's Assistant (PA)
3. Certified Registered Nurse Practitioner (CRNP)
4. Psychologist
5. Licensed Clinical Social Worker (LCSW)
6. Licensed Professional Counselor (LPC)
7. Licensed Marriage and Family Therapist (LMFT)

#### Eligibility (both A and B are required)

- A. Presence or history of serious mental illness, based upon medical records including:  
Schizophrenia  
Major Mood Disorder  
Schizoaffective Disorder  
Borderline Personality Disorder  
Post Traumatic Stress Disorder
- B. Moderate to severe functional impairment, due to the mental illness. The functional impairment limits performance in living, learning, working and/or socializing.

*\*Exception—if an individual is diagnosed with an Axis I disorder that is NOT listed above, they may qualify for services with a written description of their functional impairment (See below).*

As per the Office of Mental Health and Substance Abuse Bulletin (OMHSAS-22-08):  
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 within the current DSM 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 referenced year without the benefit of treatment or other support services are considered to have serious mental illness. Substance use disorders, developmental disorders, and neurodevelopmental disorders are not included.

Licensed Practitioner of Healing Arts Form (LPHA) Recommendation for Peer Support Services (CPS Services)

Date: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

I. Diagnosis

Diagnosis (required): \_\_\_\_\_

ICD-10-CM (required): \_\_\_\_\_

II. Functional Impairment (please complete a, b & c)

a. The individual has a moderate to severe functional impairment, due to the qualifying mental illness. The functional impairment limits performance in living, learning, working and/or socializing.

Yes No

b. The functional impairment limits performance in the following:

Living Learning Working Socializing

c. Please specify the impairment below.

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

III. Recommendation

a. I recommend the individual named above for Peer Support Services (CPS Services) based on the information I have provided on this form.

Yes No

IV. Exception (only if the individual has an Axis I diagnosis NOT listed in the Eligibility section). Please provide an explanation of the individual's functional impairment.

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

Signature: \_\_\_\_\_ License # \_\_\_\_\_

Date: \_\_\_\_\_

Print: \_\_\_\_\_ Phone: \_\_\_\_\_