Psychiatric Rehabilitation/Peer Support Services

Fax: 814-867-1493 Attn: ASA

**PLEASE ATTACH A RELEASE OF INFORMATION FORM TO SKILLS OF CENTRAL PA

FIRST NAME: ____________________________ MI: ____ LAST: ________________________________

ADDRESS: ____

PHONE: DAY ( )___________________________ EVENING ( )______________________________________

DATE OF BIRTH:________________Current Age: __________SOCIAL SECURITY #:______________________________

MA ID #:____________________GENDER IDENTITY:___________ GUARDIANSHIP STATUS:_______________

REFERRAL INFORMATION

DATE OF REFERRAL: __________

REFERRING AGENCY: ____PHONE: ( ) _________________

NAME & TITLE OF PERSON MAKING REFERRAL:

Referral being made to (check all that apply):

Mobile PR___ Peer Support ___ Opportunity Centre Clubhouse (Centre Co.) ___ Site Based PR (L/C Co.) ___

Reason for Referral: Check participant's desired goal areas and list specific skills needed in each:

__1. Living

____

__2. Wellness

____

__3. Social

____

__4. Educational

____

__5. Vocational

____

Recommendation for SKILLS:
Psychiatric Rehabilitation/Peer Support Services

Person Served: ____________________________________ **Date:** _______________________

This form shall serve as official verification that the person served above fully meets the program and the Department of Public Welfare 55 PA Code 5230 for receiving Psychiatric Rehabilitation and Peer Support Services.

1. Primary Mental Health Diagnosis: ____________________________ code: _______________
(***MUST USE ICD 10 Code***)

   ______Qualifying diagnosis (schizophrenia, major mood disorder, psychotic disorder NOS, schizoaffective disorder, borderline personality disorder.

   ______Exception diagnosis (primary mental health diagnosis) *****Diagnosis Exception (Individuals who do not meet the serious mental illness diagnosis requirement above can still receive services by documenting the current primary mental health diagnosis and completing question two).**

2. As a result of the mental illness the person has a moderate to severe functional impairment that interferes with or limits performance in at least one of the following areas (circle one):

   Social **Self-Maintenance** **Education** **Vocational** **Living**

Please give a description of functional impairment that interferes with or limits performance the checked area as a result of the mental illness.

____

____

Signature of the Physician or other practitioner of the healing arts with credentials: (Psychiatrist, Physician,

____ Date: __________________

Printed Name of Physician or other practionerof the healing arts:

____ Date: __________________