## BUCKS/MONTGOMERY COUNTY PEER SUPPORT SERVICES REFERRAL FORM

Peer Support Services involve a working partnership between the Peer Support participant and a person who is a former or current recipient of mental health and/or co-occurring substance use services. Using their shared life experience with mental illness, the participant and the Peer Support staff person work together to further the participant's wellness and meaningful daily living and community role development. This is accomplished through, but not limited to, recovery education, community resource coordination/linkage, daily living skill instruction, advocacy, and development of natural supports. Applicants May Self-Refer.

Include an updated psychiatric evaluation from within the past year..

Date of Referral:	Provider #:		
Applicant Name:		(15.7.)	
(Last) Date of Birth:	(First) Social Security #:	(M.I.)	
Address: (if homeless, last known address)			
E-mail address (optional): Work :	#: Cell #	: <u> </u>	
Type of Insurance: (check all that apply)  Medical Assistance (Specify M.A. #)  Medicare			
Reason for referral/How are you hoping to benefi	• •		
Area in which you are interested in making a chaHousingEmploymentSchooCommunity Connection Applicant Signature (required):	olPersonal wellness		
SECTION II (Complete This Section If Referral Sou	rce Is Different Than Applicant)		
Referral Source Name: Fax #:		_	
Phone #: Fax #:			
E-mail address:Additional comments:			
E-mail address:			

## **SECTION III**

## **Support Summary**

Type	Agency	Contact Person	Phone Number/Email
sychiatrist			
Mental Health Therapist			
ubstance Use Therapist			
Case Manager			
ntensive Psych Rehab Worke	r		
<u> </u>			
Clubhouse Worker			
ocational Program Worker			
Iousing Program Worker			
robation/Parole Officer			
amily Member(s)			
riend(s)			
Other			
SECTION IV (This section Primary dx:			:
		DSM	:
Secondary dx:			<u>:</u>
T		DSM	
Life Domains	Level of Impairmen		ly, circle the severity and comment):
□ Employment			<u></u>
□ Education	None Mild Modera	ate Severe	
□ Independent Living			
□ Wellness Management			
		to rec	ceive Peer Support Services.
ap	plicant name		
	A Signature		 Date
	O	O Licensed Davishele	gist, Nurse Practitioner)