Greater Reading Mental Health Alliance

Recommendation for Peer Support Services

Name: _____ DOB:_____

The following document can only be completed by a Physician, Licensed Psychologist, CRNP, or PA-C, LMFT, LPC, or LCSW. This form shall serve as official verification that the person above fully meets program and medical necessity criteria for receiving Peer Support Services.

( ) Is eighteen years of age or older
( ) Has a documented Serious Emotional Disturbance or Serious Mental Illness

Functioning Impairment **Please check all that apply:**

( ) One or more developmentally-appropriate social, behavioral, cognitive, communicative, adaptive skills.
( ) Role functioning in one or more major life activities including basic daily living skills (e.g., eating, bathing, dressing).
( ) Instrumental living skills (e.g., maintaining a household, managing money, getting around the community, taking prescribed medication).
( ) Functioning in social, family, and vocational/educational contexts.

Dx:_____
_____
_____

Printed Name of Physician, Licensed Psychologist, CRNP, or PA-C, LMFT, LPC, or LCSW

_____

Signature of Physician, Licensed Psychologist, CRNP, or PA-C, LMFT, LPC, or LCSW

_____ Date:_____