Referral Form: Community Autism Peer Specialist (CAPS) Services

Eligibility Criteria: Must have an autism diagnosis, be 14 years or older and be eligible for HealthChoices (Medicaid)

Participant Information:

Name: _____Preferred Name: _____

Preferred-Pronouns:_____Address:_____

City:_____State:_____Zip-Code:_____

Social-Security-#(**required**):_____Phone: _____ Email: _____

Date of Birth (**required**): _____ IQ Score: _____

Is this individual Health Choices (Medicaid) eligible? Yes____No____

Does Mental Health Partnerships have the Participant's permission to leave a voicemail? Yes:____No:____

Referral Information:

Name of Person Making Referral: _____ Organization:_____

Title: _____ Address: _____

City:_____ State:_____Zip Code: _____Email: _____ Phone:

_____ Date of Referral: _____

Domains *(must check at least one):*

This participant has a confirmed autism diagnosis and would benefit by improving their overall well-being in one of the following domains (*check all that apply*):

□ Social (e.g., developing relationships, social support system, community engagement)

□ Self-maintenance (e.g., managing wellness, self-advocacy, managing money, living more independently)

□ Educational (e.g., obtaining a high school, technical, or college degree)

□ Vocational (e.g., obtaining part-time or full-time employment)

Reason for Referral:

_____

_____

_____

_____

_____

_____

Community Autism Peer Specialist (CAPS) Services

MENTAL HEALTH PARTNERSHIPS
Together, we build hope.

Current Diagnosis(es) :

NOTE: Individuals referred for CAPS must have a diagnosis of an Autism Spectrum Disorder and the ability to communicate independently. Individuals who are 21 or older MUST also have a major mental health diagnosis in addition to ASD.

PRIMARY ICD-10 Code & Diagnosis: _____

Other ICD-10 Code & Diagnosis: _____

Other ICD-10 Code & Diagnosis: _____

Medical /Physical Health Issues: _____

Medical Physical Health Issues: _____

Comments/Additional Information:

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Licensed Independent Practitioner:

This form is valid for 60 days from the date it is signed by a Licensed Independent Practitioner (i.e. - Physician, Psychiatrist, Neurologist, Licensed Psychologist, Licensed Clinical Social Worker, Certified Registered Nurse Practitioner or Physician's Assistant). By signing this form, the Practitioner has reviewed the referral information, attests to its accuracy, and recommends the above-mentioned participant for Community Autism Peer Specialist services.

☐ Checking this box confirms you have received the participant's informed consent needed to share information included in this referral.

Licensed Practitioner of the Healing Arts:

This form is valid for 60 days from the date it is signed by a Licensed Practitioner of the Healing Arts (Physician, Licensed Psychologist, Certified Registered Nurse Practitioner, LCSW, LPC, LMFT or Physician's Assistant). By signing this form, the Practitioner has reviewed the referral information, attests to its accuracy, and recommends the above-mentioned participant for Certified Peer Specialist services.

Name: _____ Title: _____

Signature: _____ Date: _____

PROMISe ID #: __ __ __ __ __ __ __ __ __ NPI#: __ __ __ __ __ __ __ __ __ __ __ __ __ __

▢ *PROMISe ID: Not applicable, I, the practitioner, am not enrolled as a Medical Assistance Provider with the Pennsylvania Department of Human Services*

Program and County for Services (Fax the referral to the program):

Philadelphia County, Community Autism Peer Specialist (CAPS), Fax: (215-525-2741),

Phone: (267-234-5213)

Mental Health Partnerships:

Date Received: _____ Date Reviewed: _____Date Form Entered Into Credible: _____

Approved by (*Name and Title)*:

_____