



*The Mental Health Association
Peer Support Services*

478 Grant Street
Chambersburg, PA 17201
Phone (717) 264-4301 Fax (717) 264-3591

Recommendation for Peer Support Services

Dear Recommending Practitioner:

An individual in your care has requested Peer Support Services from the Mental Health Association. Per state requirements, we must have your referral in order to provide services through managed care. The name of the individual is listed below. Please check the box applicable to your profession and the reason for referral (a functional impairment in one or more area), print and sign your name, provide the name of your practice, and date. Thank you for your assistance.

Name of Individual: _____ **D.O.B.** _____

Individual's phone number: _____

Individual's Address: _____

Practitioner Type:

- Physician/Psychiatrist
- Psychologist
- CRNP
- PA

Reason for referral:

Moderate to Severe Functional Impairment

A functional impairment interferes with or limits (relative to the person's ethnic or cultural environment) performance in at least one of the following domains:

- Education
- Social
- Vocation
- Self Maintenance

Diagnostic Code: _____

Printed Name of Practitioner

Provider MA#

Signature of Practitioner

Date

Name of Agency

Agency NPI #

If you have any questions, please contact:

717-264-4301
info@mhaff.org

