***Instructions****: This form can only be completed and signed by a Licensed Practitioner of the Healing Arts (Individual currently**licensed as a Registered Professional Nurse, Nurse Practitioner, Psychiatrist, Licensed Psychologist, Licensed Psychoanalyst, Licensed Master Social Worker, Licensed Clinical Social Worker, Licensed Marriage & Family Therapist, Licensed Mental Health Counselor, or Licensed Creative Arts Therapist, or Physician)*

|  |
| --- |
|  DATE:  |

**Recommendation for Rehabilitative Service(s)**

|  |  |
| --- | --- |
| Participant Name: | Date of Birth: |
| Parent/Caregiver: | Relationship: |
| Address: | Phone: |
| County of Residence: | Medicaid CIN #: |

**Behavioral Health Information:** (\*A MH/SUD diagnosis is only required for a recommendation of PSR)*Check all that apply:*

|  |  |  |  |
| --- | --- | --- | --- |
| **List** | **Diagnosis Category** | **Specific Diagnosis or Symptoms of Mental Illness DXCode (MH)/Substance Use (SUD)** | **Code** |
| ***Primary*** |  |  |  |
| ***Secondary*** |  |  |  |
| ***Other*** |  |  |  |

**Areas of Functioning:** (As a result of the symptoms or diagnosis of MH/SUD, the child/youth has functional impairment thatinterferes with or limits functioning in at least one of the following areas and is likely to benefit from and respond to the service(s) recommended to prevent the onset or worsening of symptoms.) *Check all that apply:*

|  |  |  |
| --- | --- | --- |
| **Check** | **Domain**  | **Description of Impairment** |
|  | **Self-Direction/Control** |  |
|  | **Self-Care** |  |
|  | **Family Life** |  |
|  | **Social Relationships**  |  |
|  | **Symptom Management** |  |

**Recommended Child and Family Treatment and Support Service(s):** *Check all that apply:*

|  |  |  |
| --- | --- | --- |
| **Check**  | **Rehabilitative Service** | **Description of needed intervention** |
|  | **Family Peer Support Services** | * Engagement, Bridging, and Transition Support
* Self-Advocacy, Self-Efficacy and Empowerment
* Parent Skill Development
* Community Connections and Natural Supports
* Education Advocacy
 |
|  | Youth Peer Support Services | * Self-Advocacy, Self-Efficacy and Empowerment
* Community Connections and Natural Supports
* Coaching
* Engagement, Bridging, and Transition Support
* Skill Building.
 |

**Detailed Reason for Recommendation:**

|  |
| --- |
|  |

**By Signing below I am recommending the above named individual for Child and Family Treatment Support Services:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_**

**LPHA Signature Printed Name NPI # Date**

**MHA Family Support Services**

320 North Goodman St. **MHA Office Use Only:**

Rochester, NY 14607 Date Received by: \_\_\_\_\_\_\_\_\_\_\_

Office: 585-325-3145 x 152 Date Logged In by: \_\_\_\_\_\_\_\_\_\_\_\_

Email: mhafssreferral@mharochester.org Date Approved by: \_\_\_\_\_\_\_\_\_\_\_\_ Date Referred Out: \_\_\_\_\_\_\_\_\_\_\_\_

 Client ID: \_\_\_\_\_\_\_\_\_\_\_