KEYSTONE HUMAN SERVICES

Keystone Service Systems Mental Health Peer Support Referral Request

Name: _____ DOB: _____ BSU#: _____

Address: _____ City: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ SS#: _____

County: _____ Case Manager: _____ CM phone#: _____

Insurance: _____ Insurance #: _____

Any involvement with another Keystone program: _____

Admission Guidelines:

Reason for Referral: ☐Educational ☐Vocational ☐Social ☐Health & Wellness ☐Housing

Please describe specifically the Functional Impairment/need for peer support by detailing the top 3 need areas:

_____

_____

_____

ADULT PRIORITY GROUP

Must meet age from this section to continue. ☒ **Age > = 18**	**Diagnosis:** **ICD Diagnostic Codes:** _____ _____ **Past Suicide Attempts:**_____

☐ **Has met the standards for involuntary treatment (as defined in Chapter 5100 Regulations – Mental Health Procedures) within 12 months preceding the assessment is automatically assigned to the high priority group.**

Check all that apply:

☐ **A Treatment History**	☐ **Current Residence in or discharge from a state mental hospital within past 2 years** ☐ **Two admissions to community or correctional inpatient psychiatric units or residential services totaling 20 or more days within the past two years** ☐ **Five or more face to face contacts with walk in or mobile crisis or emergency services within the past two years** ☐ **One or more years of continuous attendance in a community mental health or prison psychiatric service (at least one unit of service per quarter) within the past two years** ☐ **History of sporadic course of treatment as evidenced by at least three missed appointments within the past six months, inability or unwillingness to maintain medication regimen or involuntary commitment to outpatient services** ☐ **One or more years of treatment for mental illness provided by a primary care physician or other non-mental health agency clinician, (e.g. Area Agency on Aging) within past two years**
☐ **B Functioning Level**	**GAF score_____ (only can be used as admission criteria if under 50)**
☐ **C Coexisting Condition or Circumstance**	☐ **Coexisting Diagnosis** ☐**Psychoactive Substance Use Disorder** ☐**Mental Retardation, HIV/AIDS, Sensory Impairment, Developmental and/or Physical Disability** ☐ **Homelessness (sleeping in shelters or places not meant for human habitation, such as cars, parks, sidewalks, or abandoned buildings)** ☐ **Release from Criminal Detention (applicable categories of release from criminal detention are jail diversion; expiration of sentence or parole; probation or Accelerated Rehabilitation Decision [ARD])**

KEYSTONE HUMAN SERVICES

Keystone Service Systems Mental Health Peer Support Referral Request

List all current Mental Health/Drug & Alcohol Services (therapists, psychiatrists, programs):

_____

_____

Past or Current Involvement with Peer Support:

_____

_____

Other Pertinent Information/Schedule/best time to meet/issues to be aware of:

_____

_____

_____

Contact List (family, friends):

_____

_____

Emergency Contact Info:
Name: _____ **Relationship:** _____ **Phone #:** _____

Person Completing this Referral:

Name:_____ **Title:** _____

Agency: _____ **Phone #:** _____

Agency Address: _____ **Self Referral?** ☐ **Yes** ☐ **No**

Recommendation for Medical Necessity given by:

☐**Physician** ☐**Physician Assistant** ☐**Nurse Practioner** ☐**Psychologist** ☐**Psychiatrist** ☐**Other**

Signature: _____ **Date:** _____

Printed Name: _____ **Phone #:** _____

Agency: _____ **Agency Address:** _____

By signing below, I am stating that I am interested in receiving Peer Support Services from Keystone Peer Support Unit:

Signature:
_____ **Date:** _____

PLEASE RETURN COMPLETED FORM TO:

Peer Support Supervisor
c/o Keystone Service Systems Mental Health
3700 Vartan Way, Harrisburg, PA 17110
717-482-8500/717-482-8501 fax

KEYSTONE HUMAN SERVICES

Keystone Service Systems Mental Health Peer Support Referral Request

AUTHORIZATION/REQUEST FOR RELEASE OF CONFIDENTIAL INFORMATION					
EXCHANGE OF INFORMATION (BOTH TO AND FROM) EXTERNAL AGENCY AND KEYSTONE SERVICE SYSTEMS					
Name:		Birthdate:		SS#:	**XXX-XX-**
I do hereby authorize the person and/or agency indicated to exchange such confidential information and records as specified below with Keystone Service Systems, Inc. You are hereby released from all legal liability that may arise from such release.					
Name/Title:	Account Manager	External Agency:	PerformCare		
Address: 8040 Carlson Rd. Harrisburg, PA 17112					

☐ Discharge Summary	☐ Progress Notes
☐ Educational information	☐ Psychiatric Evaluation & Diagnosis
☐ Family History	☐ Psychological/Social History
☐ Financial information	☐ Referral Form
☐ Immunization information	☐ Treatment/Behavior Plan & Recommendation
☐ Medical Examination/Recommendations	☐ Vocational Information
☐ Medications	☒ Information Required by Funding Source(s)
☐ Information relating to AIDS or HIV infection	☐ Treatment for substance abuse or dependency
☐ Psychotherapy notes	☐ Other:
☐ Other:	☐ Other:
Reason for release of information:	

This information is being disclosed to the above person, organization or agency from records whose confidentiality may be protected by the Pennsylvania Drug and Alcohol Abuse Control Act, the Pennsylvania Mental Health Procedures Act, and/or the Pennsylvania Confidentiality of HIV Related Information Act. My signature below authorizes the release of information protected by these Pennsylvania statutes.

I understand that I have no obligation whatsoever to disclose information from my record. I also understand that Keystone Service Systems, Inc. cannot withhold treatment from me based upon my failure to execute this authorization, subject to the following exception: If the only purpose for this authorization is to allow a health care provider to perform tests (such as drug tests) or other health care services and then transfer the results of such tests or services to another party, the provider conducting such tests or other services may decline to perform such tests or services if I refuse to sign this authorization.

I understand that I may revoke this authorization at any time in writing, except to the extent that action based on this authorization has been taken. However, I also understand that health information disclosed pursuant to this authorization may be subject to re-disclosure because it is no longer protected by federal privacy laws. I fully understand the contents of this authorization and voluntarily consent to the release of the information as stated. Keystone Service Systems, Inc., its employees, officers and clinical staff are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein. Finally, I understand that I am entitled to obtain a copy of this authorization from Keystone Service Systems, Inc. upon request.

This authorization shall be effective immediately and will expire on:		(date not to exceed 365 days)

Signature of Individual/Parent*/Guardian*	***Date***	***Signature of Witness***	***Date***

* Relationship if other than individual signing

I understand I have the right to a copy of this authorization.	☐ I accept a copy.	☐ I decline a copy.

Phone: 717-482-8500
Fax: 717-482-8501