Threshold

Rehabilitation Services, Inc.

Threshold Rehabilitation Services
Recommendation for Peer Support Services

In addition to the Peer Support referral form, this form is needed to admit the individual requesting service. Please complete and fax to 855-708-4804

Consumer Name: _____

Date of Birth: _____

This form shall serve as verification that the consumer fully meets program and medical necessity criteria for receiving Peer Support Services

Is sixteen years of age or older.
Has a **documented serious mental illness** within Pennsylvania adult priority population guidelines.

Diagnosis Code(s): _____

_____

_____

Has moderate to severe functional impairment in at least one of the following areas (check all that apply)

☐ Educational ☐ Vocational

☐ Social ☐ Self-maintenance

_____ _____

Signature of Psychologist/Psychiatrist/Physician/PA/CRNP Date

_____

Printed Name

Facility: _____

Address: _____

Phone Number: _____