Threshold Rehabilitation Services
Recommendation for Peer Support Services

This form is needed to admit the individual requesting services to Peer Support Services. Please complete and fax back to:
Attention: Peer Support – Jen Miller
Fax # 855-708-4804
Any questions please call: 610-777-7691

Consumer Name: _____
Date of Birth: _____

This form shall serve as official verification that the consumer above 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

Educational	Vocational
Social	Self-maintenance

_____ _____

Signature of Psychologist/Psychiatrist/Physician (PA or CRNP may also sign) Date

_____
Printed Name

Facility: _____

Address: _____

Phone Number: _____