Referral Form: Community Autism Peer Specialist (CAPS) Services

Eligibility Criteria: Must have an autism diagnosis, be 14 years or older and be eligible for HealthChoices (Medicaid)

Participant Information:

Name:_____Preferred Name: _____

Preferred Pronouns: _____ Address:_____

City:_____State:_____ Zip Code: _____ Social Security # (**required**): _____

Phone: _____ Email: _____ Date of Birth (**required**): _____

Is this individual Health Choices (Medicaid) eligible? Yes____No ____

Does Mental Health Partnerships have the Participant's permission to leave a voicemail? Yes:____No: ____

Referral Information:

Name of Person Making Referral: _____ Organization:_____

Title: _____Address:_____

City:_____ State:_____ Zip Code: _____Email: _____

Phone: _____ Date of Referral: _____

Domains *(must check at least one):*

This participant has a confirmed autism diagnosis and would benefit by improving their overall well-being in one of the following domains (*check all that apply*):

□ Social (e.g., developing relationships, social support system, community engagement)

□ Self-maintenance (e.g., managing wellness, self-advocacy, managing money, living more independently)

□ Educational (e.g., obtaining a high school, technical, or college degree)

□ Vocational (e.g., obtaining part-time or full-time employment)

Reason for Referral:

_____

_____

_____

_____

_____

Current Diagnosis(es) :

NOTE: Individuals referred for CAPS must have a diagnosis of an Autism Spectrum Disorder.

PRIMARY ICD-10 Code & Diagnosis: _____

Other ICD-10 Code & Diagnosis: _____

Other ICD-10 Code & Diagnosis: _____

Medical /Physical Health Issues: _____

Medical Physical Health Issues: _____

Comments/Additional Information:

_____

_____

_____

_____

Licensed Independent Practitioner:

This form is valid for 60 days from the date it is signed by a Licensed Independent Practitioner (i.e. - Physician, Psychiatrist, Neurologist, Licensed Psychologist, Licensed Clinical Social Worker, Certified Registered Nurse Practitioner or Physician's Assistant). By signing this form, the Practitioner has reviewed the referral information, attests to its accuracy, and recommends the above-mentioned participant for Community Autism Peer Specialist services.

☐ Checking this box confirmed you have received the participants informed consent needed to share information included in this referral.

Name:_____ Title:_____

Signature:_____ Date:_____

Program and County for Services (Fax the referral to the program):

Philadelphia County, Community Autism Peer Specialist (CAPS), Fax: (215-525-2741), Phone: (215-910-6264)

Mental Health Partnerships:

Date Received: _____ Date Reviewed: _____ Date Form Entered Into Credible: _____

Approved by (*Name and Title)*: _____