Patient Name: Date of Birth:

I am recommending that Certified Peer Support Services are medically necessary for the above patient for the following reasons with completion of the following

**Please complete Sections 1 through 4 with dated signature.**

**1. Current Behavioral Health Diagnosis with ICD 10 Code:**

                           

**2. Functional Impairments Observed:**

Activities of Daily Living  Housing Maintenance Education  Vocation  Family

Social  Self-Maintenance  Cognition  Community Integration

**3. Treatment History: Check the appropriate box for validation of services:**

Current residence in or discharge from a state mental hospital within the past two years.

Two admissions to community or correctional inpatient psychiatric units or crisis 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 the past two years.

Functioning Level Global Assessment below 50.

**4. Coexisting Condition:**

Psychoactive Substance Use Disorder Developmental Delays HIV/AIDS

Sensory  Physical Disability Homelessness

Release from criminal detention.