** For Mental Health Emergencies **

Call the 24/7 Child Priority Response Hotline: 1-800-969-4357

This is a request for PBH to authorize a Family Peer Support.

** Please note: Incomplete referrals cannot be processed and will be returned. Corrections must be received within 30 days or a new referral with current clinical information and signatures dated within the last 30 days must be re-submitted. Please allow up to 1 week for processing of a complete referral. **

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** Eligibility **

- Clients eligible for Family Peer Support must have active Medicaid.
- Youth must be active in outpatient treatment and the therapist must sign the referral.

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** Next Steps **

- If approved, PBH will send an authorization to Champions for Children’s Mental Health and they will contact you.
- If the client continues to need Family Peer Support beyond the initial authorization, a Reauthorization Request must be submitted to PBH prior to the original authorization’s end date.

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** Please Don’t Forget (if applicable) **

- **Legal guardians:** A court order indicating guardianship rights of the person who signs this form.
- Therapist’s information if they are not the referral agent
Access Department

FAMILY PEER SUPPORT - ADMISSION

DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH & THEIR FAMILIES
DIVISION OF PREVENTION & BEHAVIORAL HEALTH SERVICES
Terry Center Pod #3, 10 Central Ave., New Castle, DE 19720 1-800-722-7710

Please fill out this form as completely as possible and call if you need assistance.

Fax this form to (302) 622-4475 or mail it to the address above or email to: DSCYF_Intake_General@state.de.us

CHILD INFORMATION

Date: __________  Child’s Name: ________________________________________________

DOB: __________  Gender: □ M  □ F  Race: ______________________  Ethnicity: __________

Address: ________________________________________________________________

City: __________________________  State: _________  Zip: __________  County: __________

School: __________________________  Grade: _________  Education Type: □ Regular  □ Special

PARENT/GUARDIAN INFORMATION

Name: _________________________________________________________________

Relationship to Child**: ________________________________________________

Address: ______________________________________________________________

City: __________________________  State: _________  Zip: __________

Best Phone Number: __________________________  Other Phone: __________________________

INSURANCE INFORMATION

Active Medicaid? □ Y  □ N  Member ID #: __________

If so, which Managed Care Organization: □ None  □ Highmark Health Options  □ United Health Care

CLIENT’S DIAGNOSIS – INCLUDE DSM V CODES

9/2017
Referral Agent

Completed by: ________________________________  Organization/Agency: ________________________________

Relationship to Child: ________________________________  Position: ________________________________

Email: ________________________________

Phone: ________________________________  Fax: ________________________________

If the Outpatient Therapist is not the referral agent please fill the below:

Therapist Name: ________________________________  Agency: ________________________________

Email: ________________________________

Phone: ________________________________

Treatment Plan

What is the client being treated for?

What are the treatment goals?

What are the proposed goals/objectives for the peer support (ie: advocacy skills, caregiver self-care, navigate a particular system, identify “family goals”, build/identify natural supports)?

I understand that I am applying for DPBHS Family Peer Support services. I attest that the information listed above is correct to the best of my knowledge. I consent to the sharing of information between DPBHS and the treatment provider for funding authorization, treatment planning, and monitoring.

__________________________  __________
Signature: Parent/Legal Guardian/Custodian (circle one)  Date

__________________________  __________
Signature: Therapist/Clinician  Date

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