Access Department

FAMILY PEER SUPPORT - ADMISSION

Required Referral Information

**** 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. *****

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.

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.

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

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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: _________________________

** If this is not the parent, a guardianship court order must be provided.

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

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