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| REFERRAL DATE: | SERVICE PARTICIPANT NAME: |
| Check If INTERNAL REFERRAL | |

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| FORM INSTRUCTIONS |

1. Only ***ONE*** service provider may be referred to at a time.
2. Be specific when describing the individual’s employment goals and reason for referral.
3. ALL sections must be completed thoroughly and typed in order to make a determination of services.
4. Items should not be left blank; please indicate N/A where appropriate.
5. A verification of a Behavioral Health diagnosis is necessary for provision of services and MUST be included with the referral.
6. Verification of diagnosis is able to be completed by one of the following: CRNP, MD, Licensed Practitioner of Healing Arts (LPHA), PA, PCP. PLEASE SEND Psych Eval or Med Ed note with referral.
7. The signature of the Service Participant is required indicating an understanding that a referral for Supported Employment Services is being made.
8. Fax or email the completed referral to the provider of the Service Recipient’s choice from the list below.
9. An individual can self-refer.

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| REFERRAL SOURCE RESPONSIBILITY |

1. If the Supported Employment provider is unable to contact the referred service recipient, the referral source has the responsibility for assisting the Supported Employment provider in contacting the referred individual.
2. The referral source has the responsibility of providing a warm hand-off and introduction between the Service recipient and the new provider.

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| SUPPORTED EMPLOYMENT PROVIDERS |

**UPMC Western BH of Mon Yough** **Pittsburgh Mercy** **TCV**

412-500-4667 (Ph) 412-867-0255 (Ph) 412-461-3811 ext. 5728 (Ph)

412- 672-1262 (Fax) 412-488-4097 (Fax) 412-464-1796 (Fax)

Contact: Annmarie Sikorski- Sowa Contact: Maureen Tarr Contact: Rebekah Yohe

[sowaa2@upmc.edu](mailto:sowaa2@upmc.edu) mtarr@pittsburghmercy.org [ryohe@tcv.net](mailto:ryohe@tcv.net)

***Name of Provider where referral is being made: ONLY ONE provider may be selected****:*

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| UPMC Western BH Mon Yough  Pittsburgh Mercy TCV |

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| 1. ELIGIBILITY CRITERIA |

1. Persons eligible for Adult Supported Employment Services are 18 years of age or older, who have a Diagnosis within the DSM V (or succeeding revisions thereafter).
2. Individuals referred have a desire to gain competitive employment or receive support in obtaining education that will lead to Competitive Employment.
3. Individuals must be a resident of Allegheny County to receive this service.

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| REASON FOR REFERRAL: |

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| Section B. REFERRAL SOURCE INFORMATION | | | |
| Referral Source: | Psych Rehab  SC  ECSC  OP  Other  If Other, describe: | | |
| Referral Source Name: |  | | |
| Affiliated Agency Name: |  | | |
| Phone: |  | Cell: | Fax: |
| Email: |  | | |
| Supervisor’s Name: |  | Phone: | Email: |

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| Section C. SERVICE PARTICIPANT INFORMATION | | | | | |
| Name: | Last | | | First | |
| Alias Name: | Last | | | First | |
| Date of Birth: |  | Age | | SS# | |
| Veteran: | Yes No | If yes, year of discharge? | | | Branch: |
| Permanent Address: | *check here if Homeless* | |  | | Zip code |
| Transportation: | Own vehicle  Bus  Other  If other, describe: | | | | |
| Current Address: (*if someplace other than permanent address)* | Facility Name: | | Address: | | Phone: |
| Contact Numbers | Home: | | Cell: | | Best time to call: |
| Email Address: |  | | | | |
| Accommodations:  Accommodations  Cont’d: | TTY  Interpreter  Sign language  Ambulatory limitations  Other – Document any other special needs or requests the individual may have: | | | | |

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| Section D. Mental Health Information ***(DSM Diagnosis- Please attach a recent psychiatric evaluation or Doctor’s signature to verify diagnosis completed within past 12 months).*** | | |
| **Please include a primary behavioral health diagnosis. Other diagnoses may be included** | | |
| Behavioral Health: |  | Code: |
| Medical Conditions: |  | |
| Medications: |  | |

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| Section E. AUTHORIZATION FORM: |
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I agree to this referral and authorization. In an event I cannot be reached, or additional information is needed, I authorize other service providers or organizations listed on this referral be contacted on my behalf for the purpose of coordinating this referral.

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| Print Name:  Service Participant Signature: | |  | | Date \_\_\_\_\_\_ | |
| Print Name:  Guardian Signature: | |  | | Date | |
| Referral Source Signature: | |  | | Date | |