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: _____________________________________

Date of Referral: _____________

Domains *(must check at least one):*

This Participant experiences a functional impairment that interferes with or limits performance (relative to the person's ethnic or cultural environment) in at least 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:

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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:

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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.

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*): ____