PEER SUPPORT SERVICE REQUEST FORM

Use to request Peer Support Services

Please print clearly – incomplete or illegible forms will delay processing.

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Instructions

Submit these documents:

- This Peer Support Service Request form
- Recovery plan or Initial recovery goals
- Ensure to complete all questions in entirety to prevent a delay in processing or an adverse determination

By fax to:

1-888-725-0101

Provider Information:

Peer Support Name: _____ _____

Agency Name: _____

Agency Phone: _____ Agency Secure Fax: _____

Agency NPI: _____ Agency TIN: _____

Agency Address: _____

City: _____ State: _____ Zip: _____

Member Information:

First Name: _____ Last Name: _____

Medicaid ID: _____ Birth Date: _____ Age: _____

Primary Diagnosis ICD-10 Code: _____

Additional: _____

Has contact occurred with PCP? ☐ Yes ☐ No

Does member participate in medical management? ☐ Yes ☐ No

Current Behavioral Health Medications: _____

Current Behavioral Health Services member is receiving: _____

Is member actively participating in Behavioral Health Services? ☐ Yes ☐ No If no, explain: _____

Is member actively participating in Peer Support Services?: ☐ Yes ☐ No If no, explain: _____

Member's current stage of change: ☐ Pre-contemplation ☐ Contemplation ☐ Preparation ☐ Action ☐ Maintenance

REQUESTED AUTHORIZATION (please mark appropriate code(s) in the left column)

	Peer Support Service H0038	Requested Start Date	Requested End Date	Total Number of Units Requested	Number of Visits per Week
☐					

FUNCTIONAL OUTCOMES (choose yes or no)

1. In the last 30 days, has member been in crisis?	☐ Yes	☐ No
2. In the last 30 days, has member received inpatient or residential behavioral health care?	☐ Yes	☐ No
3. In the last 30 days, has the member had problems with sleeping or feeling sad?	☐ Yes	☐ No
4. In the last 30 days, has the member had problems with had problems with fears and anxiety?	☐ Yes	☐ No
5. In the last 30 days, has alcohol or drug use caused problems for member?	☐ Yes	☐ No
6. In the last 30 days, has member gotten in trouble with the law?	☐ Yes	☐ No
7. In the last 30 days, has member had trouble getting along with other people including family and people out the home?	☐ Yes	☐ No
8. In the last 30 days, has member had an unstable living situation?	☐ Yes	☐ No
9. Is member currently employed or attending school?	☐ Yes	☐ No

FUNCTIONAL IMPAIRMENT (IF PRESENT, SELECT SEVERITY OF IMPACT IN DAILY FUNCTIONING.)

	N/A	Mild	Moderate	Severe		N/A	Mild	Moderate	Severe
Personal Hygiene	☐	☐	☐	☐	Physical Health	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	Work/School	☐	☐	☐	☐
Medication Compliance	☐	☐	☐	☐	Relationships	☐	☐	☐	☐
Substance Use (Current)	☐	☐	☐	☐					

List Substance Used: _____

RECOVERY TASKS TO BE COMPLETED BY PEER SUPPORT TO ASSIST DURING THE RECOVERY PROCESS (Select all that apply)

Task (initial and continuation of services)
Assisting in the clinical process through: ☐ Providing feedback to the treatment team regarding identified needs of the member and the level of engagement of the member; ☐ Development of goals; ☐ Acting as an advocate, with the permission of the member, in the therapeutic alliance between the provider and the member; ☐ Encouraging a member with a low level of engagement to become actively involved in treatment; and ☐ Ensuring that the member is receiving the appropriate services of their choice and in a manner consistent with confidentiality regulations and professional standards of care;
☐ Utilizing 'lived experience' to translate and explain the recovery process step by step and expectations of services;
☐ Rebuilding, practicing, and reinforcing skills necessary to assist in the restoration of the member's health and functioning throughout the treatment process;
☐ Providing support to the member to assist them with participation and engagement in meetings and appointments
☐ Assist members in effectively contributing to planning and accessing services to aid in the member's recovery process
☐ Aiding the member in identifying and overcoming barriers to treatment and support member in communicating these barriers to treatment and service providers;

RECOVERY TASKS TO BE COMPLETED BY PEER SUPPORT TO ASSIST DURING THE RECOVERY PROCESS (Select all that apply)
Task (initial and continuation of services)
☐ Assisting the member with supporting strategies for symptom/behavior management;
☐ Supporting the member to better understand their diagnoses and related symptoms;
☐ Assisting the member with finding and using effective psychoeducational materials;
☐ Assisting the member to identify and practice self-care behaviors, including but not limited to developing a wellness recovery plan and relapse prevention planning;
☐ Explaining service and treatment options;
☐ Assisting the member to develop support systems with family and community members;
☐ Serving as an advocate, mentor, or facilitator for resolution of personal issues and reinforcement of skills necessary to enhance and improve the member's health;
☐ Fostering the member in setting goals, promoting effective skills building for overall health, safety and wellbeing that support whole health improvements and achievements of identified goals and healthy choices;
☐ Functioning as part of the member's clinical team to support the principles of self-direction to: o Assist and support the member to set goals and plan for the future; o Propose strategies to help the member accomplish tasks or goals; and o Support the member to use decision-making strategies when choosing services and supports;
☐ Providing support necessary to ensure the member's engagement and active participation in the treatment planning process.
☐ Support the member to arrange services that will assist them to meet their treatment plan goals, inclusive of identifying providers such as: o Primary care services; o Behavioral health management and treatment services; o Local housing support programs; o Supportive employment; o Education, other supportive services; o Referral to other benefit programs; and o Arranging non-emergency medical transportation.
☐ Provides support with transitioning members from a nursing facility and adjustment to community living.
☐ Involvement in treatment/clinical team
☐ Other:

Initial Request: Describe why member is in need of Peer Support Services at this time.
Renewal Requests: Describe the barriers towards specific recovery goals
Renewal Requests: Describe progress towards specific recovery goals.

Provider printed name: _____ Date _____

Provider Signature: _____ Date _____

Once completed,
Fax to: 1-888-725-0101