Journeys

Inglis' Mobile Peer Partnership

Inglis offers LTSS-competent certified peer specialist services that are supportive services aimed at promoting recovery specifically for adults with physical disabilities. Individuals requesting services MUST have a mental health diagnosis, a physical disability, and be recommended for services by a Licensed Practitioner of the Healing Arts. *This application is to be completed by the individuals requesting service and can be completed with the help of a support person.*

An LPHA from must be completed within the *last six months* and must accompany this application. This form should be completed by one of the following medical professionals: physician, physician's assistant, psychologist, or registered nurse practitioner. If the application is not complete or if the evaluation is out dated, it may be returned to you.

Section I: Demographic Information

Date of Referral:	**Referring Agency:**	**SSN:**	
Applicant's Name:	**DOB:**	**Age:**	**Gender:**
Address (if homeless, last known address): **Is your home accessible? YES ☐ NO ☐**			
Can we leave a voice mail? YES ☐ NO ☐			
Home#:	**Work#:**	**Cell#:**	**Email:**
Emergency Contact:		**Phone#:**	**Email:**

Section II: *To be completed by the applicant*:

Reason for Referral: How would you benefit from Certified Peer Specialist services? What are your needs?

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Services and Supports (Mark C for current service; P for past service; R for referral made to service; or N for needed):

Behavioral Health/Dual Diagnosis				MEDICAL		D&A	
	Partial Program		ACT		PCP		AA/NA/Dual Recovery
	Outpatient		CPS		Specialists (List):		Dual Residential Placement
	Psych Rehab		ICM/RC/BCM		Integrated BH/PH Team		Halfway House
	Service Coordinator		Enhanced Day Program		Treatments (e.g. dialysis, chemo)		Methadone Treatment
				List:			Outpatient/Co-occurring
				FORENSIC			Case Management
					Current/Pending Charges		
RESIDENTIAL					Sex Offender Program		
	Supported Housing		CRR		Probation/Parole (List Name:_____)		
	Senior Asst Living		PCBH				
	Skilled Nursing Facility		Shelter				

Section III: *To be completed by Referral Source if applicable*:

Referred by:		**Title/Position:**	
Agency:		**Phone/Email:**	

Reason for Referral? How would this person benefit from Peer Support? What are his/her needs?

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Section IV: Physical Disability

Please describe the nature of your physical disability and any tools and supports you have in place.

Section V: Insurance and Income:

Type of Insurance:	Provider:	Income Source:	Monthly Amount:
Medical Assistance		Employment	
Medicare		SSI/SSDI	
Private		Cash Assistance	
Pending, specify		Other, specify	
Spend Down specify			

Signature of Applicant:	Date:
Signature of Referral Source:	Date:

FOR OFFICE USE ONLY

LCPS Assigned:	Date Assigned:
LCPS Supervisor:	