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 Psychiatrist. *This application is to be completed by the individuals requesting service and can be completed with the help of a support person.*

A Psychiatric Evaluation completed within the *last six months* must accompany this application. 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:** Click or tap here to enter text. | | **Referring Agency:** Click or tap here to enter text. | | | **SSN:**Click or tap here to enter text. | | |
| **Applicant’s Name:**Click or tap here to enter text. | | | | **DOB:** Click or tap here to enter text. | **Age:**Click or tap here to enter text. | | **Gender:**Click or tap here to enter text. |
| **Address (if homeless, last known address):** Click or tap here to enter text.  **Is your home accessible? YES  NO** | | | | | | | |
| **Can we leave a voice mail? YES  NO** | | | | | | | |
| **Home#:**Click or tap here to enter text. | **Work#:**Click or tap here to enter text. | | **Cell#:**Click or tap here to enter text. | | | **Email:**Click or tap here to enter text. | |
| **Emergency Contact:**Click or tap here to enter text. | | | **Phone#:**Click or tap here to enter text. | | | **Email:**Click or tap here to enter text. | |

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

Reason for Referral: How would you benefit from Peer Support Services? What are your needs? Click or tap here to enter text.

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 | |
| Choose an item. | Partial Program | Choose an item. | ACT | Choose an item. | PCP | Choose an item. | AA/NA/Dual Recovery |
| Choose an item. | Outpatient | Choose an item. | CPS | Choose an item. | Specialists (List): | Choose an item. | Dual Residential Placement |
| Choose an item. | Psych Rehab | Choose an item. | ICM/RC/BCM | Choose an item. | Integrated BH/PH Team | Choose an item. | Halfway House |
| Choose an item. | Service  Coordinator | Choose an item. | Enhanced Day Program | Choose an item. | Treatments (e.g. dialysis, chemo) | Choose an item. | Methadone Treatment |
|  |  |  |  | List: | | Choose an item. | Outpatient/Co-occurring |
|  |  |  |  | FORENSIC | | Choose an item. | Case Management |
|  |  |  |  |  | Current/Pending Charges | Choose an item. |  |
| RESIDENTIAL | | | |  | Sex Offender Program | Choose an item. |  |
| Choose an item. | Supported Housing | Choose an item. | CRR |  | Probation/Parole (List Name:\_Click or tap here to enter text. | | |
| Choose an item. | Senior Asst Living | Choose an item. | PCBH |  |  |  |  |
| Choose an item. | Skilled Nursing Facility | Choose an item. | Shelter |  |  |  |  |

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

|  |  |  |  |
| --- | --- | --- | --- |
| **Referred by:** | Click or tap here to enter text. | **Title/Position:** | Click or tap here to enter text. |
| **Agency:** | Click or tap here to enter text. | **Phone/Email:** | Click or tap here to enter text. |

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

Click or tap here to enter text.

Section IV: Physical Disability

|  |
| --- |
| Please describe the nature of your physical disability and any tools and supports you have in place. Click or tap here to enter text. |

Section V: Insurance and Income:

|  |  |  |  |
| --- | --- | --- | --- |
| **Type of Insurance:** | **Provider:** | **Income Source:** | **Monthly Amount:** |
| Medical Assistance | Click or tap here to enter text. | Employment | Click or tap here to enter text. |
| Medicare | Click or tap here to enter text. | SSI/SSDI | Click or tap here to enter text. |
| Private | Click or tap here to enter text. | Cash Assistance | Click or tap here to enter text. |
| Pending, specify | Click or tap here to enter text. | Other, specify | Click or tap here to enter text. |
| Spend Down specify | Click or tap here to enter text. |  |  |

|  |  |
| --- | --- |
| Signature of Applicant: Click or tap here to enter text. | Date: Click or tap here to enter text. |
| Signature of Referral Source:Click or tap here to enter text. | Date:Click or tap here to enter text. |

FOR OFFICE USE ONLY

|  |  |
| --- | --- |
| LCPS Assigned: Click or tap here to enter text. | Date Assigned: Click or tap here to enter text. |
| LCPS Supervisor: Click or tap here to enter text. | |