



Child & Family Focus, Inc.

**Certified Peer Support for Transition Age Youth (Ages 14-26)
Licensed Practitioner of the Healing Arts (LPHA)
Recommendation**

Date:

Name of youth/young person: _____ Date of Birth: _____

Address: _____ Phone Number: _____

Name and discipline of LPHA*: _____

Describe Medical Necessity: _____

Five axes Diagnosis: _____

Evidence of related difficulties impacting daily functioning: _____

Service Recommendation: Peer Support Services- beginning effective _____

Please check how the person would benefit from peer support:

- Resiliency/Recovery Planning
- Develop Community Supports
- Educational/Vocational Support
- Continuity of Care
- Transitional Planning
- Other Specify _____

I hereby certify and recommend the above named person for peer support services

Date:

Signature (*must be either a Licensed Psychiatrist, Psychologist, Physician, Physician's Assistant or a Certified Registered Nurse Practitioner)

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