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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