ST PETER'S HEALTH PARTNERS
A Member of Trinity Health

Personalized Recovery Oriented Services (PROS) Referral Form

Complete this form and fax to (518) 271-1791, Attention: PROS Referral.

To discuss possible referrals, phone contact can be made at 518-271-1122.

The Client Must:

1. Have Medicaid
2. Be 18 Years of Age or Older
3. Have a Serious Mental Illness (SMI)
4. Functional Deficit Due to Serious Mental Illness

As part of our admission / review process, the following paperwork is needed to determine eligibility for PROS:

- Fully Completed PROS Referral Form
- A current Psychosocial / Psychiatric Assessment (done within the last 12 months)
- An Identified Life Goal (A desire to change an area of: living, learning, working or socializing)
- A Current Medication Sheet. (If clinical referral, recipient MUST have minimum a 30-day supply of medication)
- Consent Form

Recipient's Demographic Information		
Date of Referral		
Name:	Date of Birth:	Age:
Social Security Number:	Phone Number:	
Sex assigned at Birth:	Pronouns:	
Gender Identity ☐ Male ☐ Transman ☐ Gender nonconforming ☐ Female ☐ Transwoman ☐		
Recipient's current living situation: ☐ Currently has housing ☐ At risk of homelessness ☐ Currently homeless ☐Other, specify:		
Address:		
(Must have Medicaid) Medicaid CIN#:	Managed Care Organization: ☐ CDPHP ☐ Fidelis ☐ MVP ☐ WellCare ☐ Medicare ☐ Other, specify:	
Reason for Referral & Life Goal		
Functional disability deficit due to SMI that rises to the level of impairment in one or more of the following areas		
☐ Self – Care ☐ Activities of Daily Living ☐ Interpersonal Relations ☐ Adaptation to Change ☐ Performance in Work or Work-Like Setting ☐ Other:		
Recipient Information: (ICD 10 Code)		
Primary Psychiatric Diagnosis:		
Secondary Psychiatric Diagnosis:		
Substance/ Alcohol Abuse:		
Medical Diagnosis:		

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Current Psychiatric Medications
Does this recipient take a long acting injectable (LAI) medication Last date received_____ Next date due _____
Safety Concerns Please check or specify any concerns that you are aware of and provide any additional information that may be helpful.
☐ Risk to Self ☐ History of Aggressive Behavior ☐ Access to Firearms ☐ Registered Sex Offender ☐ Other, specify: _____
Has the Recipient experienced a recent hospitalization due to mental illness? ☐ Yes ☐ No ☐ Unsure If yes, please provide discharge date:
Has the Recipient experienced a recent inpatient stay for substance abuse treatment? ☐ Yes ☐ No ☐ Unsure If yes, please provide discharge date:
Has the Recipient ever experienced an incarceration? ☐ Yes ☐ No ☐ Unsure If yes, please provide details and release date:
Is the client on AOT (Assisted Outpatient Treatment) / Enhanced Service Package: ☐ Yes ☐ No ☐ Unsure If yes, please provide a copy of AOT order
Current Clinical Provider:
Psychiatrist:
Primary Care Physician:
Care Manager Name & Agency:
How often is client seen at your agency: Date last seen:
Is client consistent with appointments: ☐ Yes ☐ No If no, Please explain
Is the client aware that they are being referred to PROS: ☐ Yes ☐ No If no, Please explain
Referral Source Information
I, the undersigned LPHA based upon examination of the recipient of services, am referring the above-named individual for PROS. I understand that the eligibility for services will be determined based on the information provided.

Signature:	Printed Name:
Title:	License No.:
Clinic / Agency Name:	Address:
Phone Number:	
Email:	