## LPHA Recommendation Form

**Recommendation for Community Oriented Recovery and Empowerment (CORE) Services**

*Determination of Medical Necessity*

**Part 1: HARP Eligibility**

*Instructions:* This section may be completed by the care coordinator, Managed Care Organization (MCO), CORE Services Designated Provider, LPHA, or any other entity with appropriate access to the client record.

*Member Name:* _____

*Member DOB:* _____ *Member Phone #:* _____

*HARP Eligibility Status:*

- ☐ H1: HARP-Enrolled
- ☐ H4: HIV-SNP-Enrolled, meets NYS BH high-needs criteria
- ☐ H9: meets NYS BH high-needs criteria[13]
- ☐ Other: _____

**Part 2: Recommendation for Services**

*Instructions:* This section must be completed by a Licensed Practitioner of the Health Arts (LPHA), as defined by:

- Nurse Practitioner
- Physician
- Physician Assistant
- Psychiatric Nurse Practitioner
- Psychiatrist
- Psychologist
- Registered Professional Nurse
- Licensed Mental Health Counselor
- Licensed Creative Arts Therapist
- Licensed Marriage & Family Therapist
- Licensed Psychoanalyst
- Licensed Clinical Social Worker
- Licensed Master Social Worker, under the supervision of an LCSW, licensed psychologist, or psychiatrist employed by the agency

Note: The CORE Services designated provider will conduct an intake and engage the individual through person-centered planning to determine frequency, scope, and duration of recommended services.

*Recommended Services*

Select all that apply:

- ☐ Community Psychiatric Support and Treatment (Therapy Services)
- ☐ Psychosocial Rehabilitation
- ☐ Family Support and Training
- ☐ Empowerment Services – Peer Support

*Determination of Medical Necessity*

Based on my knowledge of the individual and clinical expertise, the individual needs and/or would benefit from the above selected CORE Services for the following reasons:

Select all that apply:

- ☐ To increase capacity to better manage treatments for diagnosed illnesses
- ☐ To prevent worsening of symptoms
- ☐ To restore/rehabilitate functional level
- ☐ To increase compensatory supports
- ☐ To facilitate participation in the individual's community, school, work, or home
- ☐ To sustain recovery lifestyle
- ☐ To strengthen resiliency, self-advocacy, self-efficacy and/or empowerment
- ☐ To build and strengthen natural supports, including family of choice
- ☐ To improve effective utilization of community resources

*Diagnosis*

DSM-5 or ICD-10 diagnoses, if known: _____

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| *Signature of LPHA* | *Date* | *Printed Name* | *NPI #* |

E-mail core@bhsn.org Fax: (518) 324-1020

[13] Individuals falling into this category are eligible to receive CORE Services when enrolled in a HARP or HIV-SNP. Eligible individuals with an H9 wishing to enroll in a HARP or HIV-SNP may contact NY Medicaid Choice at 1-855-789-4277 for enrollment options.

# Community Oriented Recovery and Empowerment Services (CORE)
# Non-Licensed/Self-Referral Form

Return form to: Sam Farrell, Program Admin
E-mail: core@bhsn.org Fax: (518) 324-1020
BHSN, 22 US Oval, Suite 122, Plattsburgh, NY 12903

| | | | |
|---|---|---|---|
| Participant Name | | Date of Birth | |
| Address | | Care Manager | |
| Phone | | Insurance | |
| Medicaid CIN # | | Insurance ID # | |

| List | Diagnosis Category | Specific Diagnosis | DX Code |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Recommend the following service(s): INITIAL all that apply:

| **INITIAL | Rehabilitative Service(s) |
|---|---|
| | **CPST - Community Psychiatric Support & Treatment** (therapeutic services & functional improvement) |
| | **FST—Family Support and Training** (instruction, support, and skill building to connect/reconnect the family) |
| | **Peer - Peer Empowerment Services** (peer delivered focused on rehabilitation, recovery, and resilience) |
| | **PSR - Psychosocial Rehabilitation** (assist in improvement of functioning at home, at work, or in the community) |

Based on my knowledge of the individual and clinical expertise, the individual needs and/or would benefit from CORE Services for the following reasons:

- ☐ To increase capacity to better manage treatments for diagnoses illnesses
- ☐ To prevent worsening of symptoms
- ☐ To restore/rehabilitate functional level
- ☐ Increase ability to identify and advocate for effective supports
- ☐ To facilitate active participation in the individual's community, school, work, or home
- ☐ To sustain wellness and recovery-oriented life skills
- ☐ To strengthen resilience, self-advocacy, self-efficacy, and/or empowerment
- ☐ To build and strengthen natural supports, including family of choice
- ☐ To improve effective utilization of community resources
- ☐ Other: _____

*For Office Use Only*

**Information Below to be completed by a practitioner of the healing arts defined as:**

**By signing below, I am recommending the above-named individual for Community Oriented Recovery and Empowerment service(s)

| **LPHA Signature | Printed Name | NPI # | Date |
|---|---|---|---|
| | | | |

| Name | Phone | Email | Agency / office |
|---|---|---|---|
| | | | |

Referral Source:

Agency:

Individual Name:

Contact Information: