100 Corporate Crossing Road
Uniontown, PA 15401
Phone: (724) 439-9311
Fax: (724) 439-9334
E-mail: info@unionstationclubhouse.org

Dear Referrer or Referring Agency:

In compliance with regulations set forth by the Pennsylvania Department of Public Welfare, perspective Union Station Clubhouse members will need the following documents for admission to the program:

- A signed release form.
- The most CURRENT psychiatric evaluation from a mental health professional.
- The attached recommendation form, signed from a Licensed Practitioner of the Healing Arts (LPHA) stating the member's diagnoses as well as what they recommend which goals the member would like to pursue while attending the Union Station Clubhouse.
    - The form can only be signed by one of the following:
        - Medical Doctor, Psychiatrist (M.D., D.O.)
        - Physician's Assistant (PA, PA-C)
        - Certified Registered Nurse Practitioner (CRNP)
        - Psychologist (Psy. D., Psy. ABD)
    - Additionally, as of January 1, 2018, the LPHA will be REQUIRED to list their PROMISEe number as well as their NPI number.

Please make sure all forms are filled out completely and correctly as to avoid delays in processing.

If you have any questions or need assistance, please do not hesitate to contact the Union Station Clubhouse staff at (724) 439-9311.

Union Station Clubhouse

Referral Form

Person Making Referral: _____

Individual/Agency Submitting the Referral: _____

Individual/Agency Phone Number: _____

Date of Referral: _____

Member Demographics

Individual Name: _____

Address: _____

City: _____ ZIP Code: _____

Contact Phone: _____ E-mail: _____

Date of Birth: _____ Medicaid ID #: _____

Social Security #: _____

General Reason for Referral: _____
_____

PR Domain Interest Areas (check all that apply): Living _____ Learning ____

Working_____ Social _____ Wellness_____

Mental Health Information

Axis	ICD9 Code	Clinical Name
I	*F* _____.____	_____
II	*F* _____.____	_____
III	*F* _____.____	_____
IV	*F* _____.____	_____
V	*F* _____.____	_____

Union Station Clubhouse

100 Corporate Crossing Road
Uniontown, PA 15401

Permission for Use/Disclosure of Health Information

Member Name: _____

SSN: _____ DOB: _____

I give my consent to _____to disclose information from my record to _____Union Station Clubhouse_____ for the purpose of:

X Determining eligibility for Union Station Clubhouse
__ Other: _____

I understand that the information released will be limited to the following marked items:

____	Diagnosis	___	General Physical
____	Attendance	_X_	Psychiatric Evaluation
____	Prognosis	____	Medications/Rx
____	Educational Goals	____	Other (please specify):
____	Vocational Goals	__X ___	LPHA Letter_____

I understand that I have the right to revoke this Authorization at any time. I may not revoke it to the extent that Union Station Clubhouse has already relied upon it, of if this Authorization was signed as a condition of obtaining insurance coverage. In order to revoke this authorization, I understand that I must do so in writing. I also understand that information used or disclosed under this Authorization could potentially be re-disclosed by the person receiving the information and may no longer be subject to the privacy protections provided to me by law.

Date: _____ Signature: _____

This Authorization expires on: _____

Date: _____ Witness: _____

If you are the legal representative of the person listed above, please note the basis for your authority:

□ Power of Attorney (attach copy) □ Guardianship Order (attach copy)
□ Custody Order (attach copy)

Union Station Clubhouse

100 Corporate Crossing Road, Uniontown, PA 15401
Phone: (724) 439-9311 Fax: (724) 439-9334
Web: www.unionstationclubhouse.com

To whom it may concern:

Please complete the attached form so the individual requesting to participate in the Union Station Clubhouse program of Goodwill of Southwestern Pennsylvania will be permitted to begin the program.

As per Pennsylvania Department of Public Welfare regulations, we are required to receive a recommendation from a Licensed Practitioner of the Healing Arts (LPHA).

A Licensed Practitioner of the Healing Arts (LPHA)must ONLY be one of the following:

- The form can only be signed by one of the following:
  - Medical Doctor, Psychiatrist (M.D., D.O.)
  - Physician's Assistant (PA, PA-C)
  - Certified Registered Nurse Practitioner (CRNP)
  - Psychologist (Psy. D., Psy. ABD)

Additionally, as of January 1, 2018, the LPHA will be REQUIRED to list their PROMISEe number as well as their NPI number in order for the member to attend the program.

After completion, please FAX the form to the attention of Scott Bombach, Program Director of Union Station Clubhouse at (724) 439-9334 or mail to:

Union Station Clubhouse
100 Corporate Crossing Road
Uniontown, Pennsylvania 15401-3347

Thank you in advance for your cooperation.

Sincerely,

Scott Bombach, B.S., CPRP
Program Director
Union Station Clubhouse
Affiliate of Goodwill of Southwestern Pennsylvania

Union Station Clubhouse

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Phone: (724) 439-9311 Fax: (724) 439-9334
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As a Licensed Practitioner of the Healing Arts (LPHA). I recommend the following individual,

_____ to be a member of Union Station Clubhouse (an affiliate of Goodwill of Southwestern Pennsylvania) to work on one of the following environments:

_____ Living ____Learning _____ Working ____ Social ____ Wellness

The individual has the following Mental Health Diagnosis listed on one of the two AXIS:

AXIS I: F._____.____ / F _____.____

AXIS II: F._____.____ / F _____.____

Please write a short comment as to how the individual will benefit from participating in the Union Station Clubhouse Program:

_____

_____

_____

Printed Name & Credentials of LPHA: _____

Signature and credentials of LPHA:_____

PROMISe #; _____

NPI #: _____

Date of Signature: _____