



# Union Station Clubhouse

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

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### 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 \_\_\_\_\_

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### Mental Health Information

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



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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, Attendance, Prognosis, Educational Goals, Vocational Goals, General Physical, Psychiatric Evaluation, Medications/Rx, Other (please specify):, 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)



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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.*

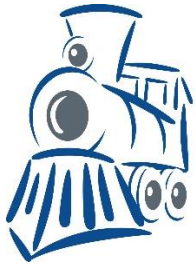
*After completion, please FAX the form to the attention of Scott Bombach, Program Director of Union Station Clubhouse at (724) 439-9334 or mail to:*

*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*



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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:*

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*Printed Name & Credentials of LPHA:* \_\_\_\_\_

*Signature and credentials of LPHA:* \_\_\_\_\_

*PROMISE #:* \_\_\_\_\_

*NPI #:* \_\_\_\_\_

*Date of Signature:* \_\_\_\_\_