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HEALTH SERVICES, LLC

Referral for Psychiatric Rehabilitation Program (Adult-PRP)

Referral Source Information: ☐ Initial ☐ Re-Referral

Name of person / agency making referral:		**Date of Referral:**	
Address:			
City/ State/ Zip Code			
Mental Health Treatment Being Provided	☐ Outpatient Mental Health Services ☐ Inpatient Mental Health Services ☐ Residential Treatment Center		

Consumer Information:

Name:		**Date of Birth:**		**Age:**	
Address:		**City, State, Zip:**			
Phone #:		**Medicaid #**			
Sexual Orientation	☐ **Heterosexual** ☐ **Gay/Lesbian** ☐ **Bisexual** ☐ **Something Else, Please Describe:** ☐ **Don't Know** ☐ **Decline**	**Language Preference:**			
Race/Ethnicity:	☐ **Amer. Indian/Alaskan Native** ☐ **Asian** ☐ **White** ☐ **Black/African American** ☐ **Native American / Hawaiian or Other Pacific Islander** ☐ **Hispanic** ☐ **Non-Hispanic**				
Gender Identification	☐ **Male** ☐ **Female** ☐ **Transgender Male/Trans Man/(F to M)** ☐ **Transgender Female/Trans Woman/(M to F)** ☐ **Genderqueer (or gender nonconforming)** ☐ **Additional Gender Category, please specify:** ☐ **Decline**				
Access to Transportation for On Site Activities:	☐ Yes ☐ No				

This form must be filled out in its entirety in order to allow for medical necessity and authorization for services. Please do not add diagnoses to the form.

CATEGORY A

☐ F20.9 Schizophrenia
☐ F20.81 Schizophreniform Disorder
☐ F25.1 Schizoaffective Disorder, Depressive
☐ F29 Unspecified Schizophrenia Spectrum and Other Psychotic Disorder
☐ F25.0 Schizoaffective Disorder, Bipolar Type
☐ F28 Other Specified Schizophrenia Spectrum and Other Psychotic Disorder
☐ F22 Delusional Disorder
☐ F31.2 Bipolar I, Most Recent Manic, with Psychosis
☐ F31.5 Bipolar I, Most Recent Depressed, w/o Psychosis
☐ F33.3 MDD, Recurrent, With Psychotic Features

CATEGORY B (If box is checked, answer questions below)

☐ F31.4 Bipolar I, Most Recent Depressed, Severe
☐ F31.0 Bipolar I, Most Recent Hypomanic
☐ F31.9 Bipolar I, Most Recent Hypomanic, Unspecified
☐ F31.13 Bipolar I, Most Recent Manic, Severe
☐ F33.2 MDD, Recurrent Episode, Severe
☐ F31.81 Bipolar II Disorder
☐ F60.3 Borderline Personality Disorder

PART I

1. Has the individual been found not competent to stand trial or not criminally responsible and is receiving services recommended by a Maryland Department of Health Evaluator? ☐ Yes ☐ No, ***If yes, explain***:

2. Is the individual in a Maryland State psychiatric facility with a length of stay of more than 3 months who requires RRP upon discharge? (Select No, if individual is eligible for Developmental Disabilities Services) ☐ Yes ☐ No, ***If yes, explain***:

3. Is the individual eligible for full funding for Developmental Disabilities Administration services? ☐ Yes ☐ No, ***If yes, explain***:

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4. Is the primary reason for the individual's impairment due to an organic process or syndrome, intellectual disability, a neurodevelopmental disorder or neurocognitive disorder? ☐ Yes ☐ No, ***If yes, explain***:

5. Is individual currently receiving mental health treatment from a licensed mental health professional? ☐ Yes ☐ No, ***If yes, explain***:

PART II

1. Does this person receive remuneration in any form from the PRP? ☐ Yes ☐ No
2. Duration of current episode of treatment provided to this individual**
   ☐ Less than one month ☐ 1-3 months ☐ 4-6 months ☐ 7-12 months ☐ More than 12 months
3. Current frequency of treatment provided to this individual:**
   ☐ At least 1x/week ☐ At least 1x/2 weeks ☐ At least 1x/month ☐ At least 1x/3 months ☐ At least 1x/6 months
4. Has this individual received PRP services from at least one other PRP within the past year? ☐ Yes ☐ No

Please indicate which of the following program(s) the individual is also receiving services from:*

1. Mobile Treatment/Assertive Community Treatment (ACT): ☐Not Applicable ☐Currently ☐In past 30 days
2. Inpatient Psychiatric Treatment: ☐Not Applicable ☐Currently ☐In past 30 days
3. Residential SUD Treatment Service Level 3.3: ☐Not Applicable ☐Currently ☐In past 30 days
4. Residential SUD Treatment Service Level 3.5: ☐Not Applicable ☐Currently ☐In past 30 days
5. Residential SUD Treatment Service Level 3.7: ☐Not Applicable ☐Currently ☐In past 30 days
6. Mental Health Intensive Outpatient Program (IOP): ☐Not Applicable ☐Currently ☐In past 30 days
7. Mental Health Partial Hospital Program: ☐Not Applicable ☐Currently ☐In past 30 days
8. SUD Intensive Outpatient Program (IOP) Level 2.1: ☐Not Applicable ☐Currently ☐In past 30 days
9. SUD Partial Hospitalization Program (PHP) Level 2.2: ☐Not Applicable ☐Currently ☐In past 30 days
10. Residential Crisis ☐Not Applicable ☐Currently ☐In past 30 days
11. If currently in treatment in one of the services listed above, a written transition plan will be attached to this request:

Primary Medical Diagnoses:

Social Elements Impacting Diagnosis

☐ None	☐ Access to Health Care	☐ Housing Problems	☐ Social Environment
☐ Educational	☐ Legal System/Crime	☐ Occupational	☐ Homelessness
☐ Financial	☐ Primary Support	☐ Other Psychosocial/Enviro.	☐ Unknown

FUNCTIONAL CRITERIA

Per medical necessity criteria, at least three of the following must have been present on a continuing or intermittent basis over the past two years.

Functional Impairment(s):

☐ Marked inability to establish or maintain competitive employment.
☐ Marked inability to perform instrumental activities of daily living (eg: shopping, meal preparation, laundry, basic housekeeping, medication management, transportation, and money management).
☐ Marked inability to establish/maintain a personal support system
☐ Deficiencies of concentration/ persistence/pace leading to failure to complete tasks.

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☐ Unable to perform self-care (hygiene, grooming, nutrition, medical care, safety)
☐ Marked deficiencies in self-direction, shown by inability to plan, initiate, organize and carry out goal directed activities.
☐ Marked inability to procure financial assistance to support community living**.**

Duration of Impairment(s):

Marked functional impairment has been present for less than 2 years. **Yes**☐ **No**☐
Has demonstrated marked impaired functioning primarily due to a mental illness in at least three of the areas listed above at least 2 years. **Yes**☐ **No**☐

Current Medications:

Is the individual med compliant: ☐yes ☐no

Presenting Symptoms: (Please include hx of Severity of Illness and History of Illness)

Criminal History- ☐yes ☐no

REASON FOR REFERRAL: *(Indicate the areas you want the PRP to address.)*

1) **Self-care skills-** ☐personal hygiene, ☐grooming, ☐nutrition, ☐dietary planning, ☐food preparation, ☐self-administration of medication.
2) **Social Skills-** ☐community integration activities, ☐developing natural supports, ☐developing linkages with and supporting the individual's participation in community activities.
3) **Independent living skills-** ☐skills necessary for housing stability, ☐community awareness, ☐mobility and transportation skills, ☐money management, ☐accessing available entitlements and resources, ☐supporting the individual to obtain and retain employment, ☐Health promotion and training, ☐individual wellness self management and recovery.

Mental Health Practitioner:

Name:	Date:
Signature:	Date:

Attach a copy of the current Treatment Plan.

PRP Staff: Date Referral, Assertion of Need & Tx Plan Received*:* _____ Screening Scheduled within 5 days?: ____ Yes _____ No