CONNECT INC.

Psychiatric Rehabilitation Program (PRP) Referral Form –Adults & Minors

Please fax the referral to +1 443 331 2476 or email it to info@theconnectrs.com

REFERRAL DATE: _____ HOW DID YOU HEAR ABOUT PRP?_____

CLIENT NAME : _____ DATE OF BIRTH: _____

GENDER: _____ RACE: _____ ETHNICITY: ☐ HISPANIC/LATINO ☐ NOT HISPANIC/LATINO

ADDRESS:_____

_____

PHONE : _____ E MAIL: _____

MEDICAL ASSISTANCE NUMBER : _____

EMERGENCY CONTACT: _____ RELATIONSHIP TO CLIENT: _____

ADDRESS: _____

PHONE: _____ EMAIL: _____

LIVING SITUATION / CONDITION

☐ PRIVATE RESIDENCE ☐ FOSTER HOME ☐ RESIDENTIAL FACILITY ☐ CRISIS RESIDENCE ☐ CORRECTIONAL FACILITY

☐ INPATIENT FACILITY ☐ GROUP HOME ☐ HOMELESS SHELTER ☐ OTHER _____

PREGNANT

☐ YES DUE DATE:_____ ☐ NO ☐ NOT APPLICABLE

MILITARY SERVICE

☐ YES ☐ NO TIME SERVED: _____

MARITAL STATUS

☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOW/WIDOWER ☐ NOT AVAILABLE

HIGHEST LEVEL OF SCHOOL COMPLETED: _____

IS THE INDIVIDUAL CURRENTLY PARTICIPATING IN ANY OF THE FOLLOWING:

☐ MOBILE TREATMENT SERVICES
☐ ASSERTIVE COMMUNITY TREATMENT (ACT)
☐ ADULT TARGETED CASE MANAGEMENT (TCM)
☐ INPATIENT
☐ METAL HEALTH -RESIDENTIAL TREATMENT CENTER (RTC)
☐ RESIDENTIAL SUD TREATMENT LEVEL 3.3 AND HIGHER
☐ SUBSTANCE USE DISORDER INTENSIVE OUTPATIENT/2.1
☐ MENTAL HEALTH INTENSIVE OUTPATIENT / PARTIAL HOSPITALIZATION PROGRAM
☐ RESIDENTIAL CRISIS

DSM BEHAVIORAL DIAGNOSES: CATEGORY A

(AT LEAST ONE DIAGNOSIS MUST BE SELECTED; SELECT NUMBER 1 OR 2):

PRIORITY POPULATION DSM-5/ICD-10 BEHAVIORAL DIAGNOSES: CLIENT MUST HAVE ONE OF THESE DIAGNOSES AS A PRIMARY TO BE ELIGIBLE FOR SERVICES - **CATEGORY A**

- ☐ **F20.1/295.10-SCHIZOPHRENIA, DISORGANIZED**
- ☐ **F20.2/295.20-SCHIZOPHRENIA, CATATONIC**
- ☐ **F20.0/295.30- SCHIZOPHRENIA, PARANOID**
- ☐ **F20.81/295.40-SCHIZOPHRENIFROM DISORDER**
- ☐ **F25.0/295.70-SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE**
- ☐ **F25.1/295.70-SCHIZOAFFECTIVE DISORDER, DEPRESSIVE TYPE**
- ☐ **F33.3/296.34-Major Depressive Disorder, Recurrent Episode WITH PSYCHOTIC FEATURES**
- ☐ **F31.2/296.44-BIPOLAR I, MOST RECENT MANIC, WITH PSYCHOTIC FEATURES**
- ☐ **F31. / - BIPOLAR 1, RECURRENT, SEVERE, WITH PSYCHOTIC FEATURES**
- ☐ **F31.5/296.54-BIPOLAR I, MOST RECENT EPISODE DEPRESSED WITH PSYCHOTIC FEATURES**
- ☐ **F31. / - BIPOLAR 1 DISORDER, RECURRENT EPISODE DEPRESSED, SEVERE, WITH PSYCHOTIC FEATURES**
- ☐ **OTHER SPECIFIED SCHIZOPHRENIA SPECTRUM DISORDER**
- ☐ **OTHER SPECIFICED PSYCHOTIC DISORDER**
- ☐ **UNSPECIFIED SCHIZOPHRENIA SPECTRUM DISORDER**
- ☐ **UNSPECIFIED PSYCHOTIC DISORDER**
- ☐ **F22/297.10- DELUSIONAL DISORDER**

☐ **HAS THE INDIVIDUAL FOUND TO BE NON-COMPETENT TO STAND TRIAL OR NOT CRIMINALLY RESPONSIBLE DUE TO A MENTAL DISORDER PURSUANT TO CRIMINAL PROCEDURE?**

☐ **IS THE CLIENT AN INDIVIDUAL IN A MARYLAND STATE PSYCHIATRIC FACILITY WITH A LENGTH OF STAY OR MORE THAN 3 MONTHS WHO REQUIRES RESIDENTIAL REHABILITATION PROGRAM (RRP) SERVICES UPON DISCHARGE?**

☐ **1. THE INDIVIDUAL IS CURRENTLY ENROLLED IN SSI OR SSDI**

☐ **2. THE INDIVIDUAL DEMONSTRATES IMPAIRED ROLE FUNCTIONING FOR AT LEAST TWO YEARS IN THREE OF THE FOLLOWING CATEGORIES:**

☐ **a. MARKED INABILITY TO ESTABLISH OR MAINTAIN INDEPENDENT COMPETITIVE EMPLOYMENT**
Must Document Clinical Evidence:

☐ **b. MARKED INABILITY TO ESTABLISH OR MAINTAIN PERSONAL SUPPORT SYSTEM**
Must Document Clinical Evidence:

☐ **c. MARKED OR FREQUENT DEFICIENCIES OF CONCENTRATION, PERSISTENCE OR PACE**
Must Document Clinical Evidence:

☐ **d. MARKED INABILITY TO PERFORM OR MAINTAIN SELF-CARE**
Must Document Clinical Evidence:

☐ **e. MARKED DEFICIENCIES IN SELF-DIRECTION**
Must Document Clinical Evidence:

☐ **f. MARKED INABILITY TO PROCURE FINANCIAL ASSISTANCE TO SUPPORT COMMUNITY LIVING**
Must Document Clinical Evidence:

DSM BEHAVIORAL DIAGNOSES: CATEGORY B

(AT LEAST ONE DIAGNOSIS MUST BE SELECTED AND QUESTION ONE MUST BE TRUE FOR THE INDIVIDUAL):

☐ **F33.2/296.33-Major Depressive Disorder, CURRENT EPISODE, SEVERE W/O PSYCHOSIS**

☐ **F31.13/296.43-BIPOLAR I DISORDER, MOST RECENT MANIC, SEVERE**

☐ **F31.13/296.43-BIPOLAR I DISORDER, MOST RECENT, DEPRESSED, SEVERE**

☐ **F31.13/296.43-BIPOLAR I DISORDER, MOST RECENT HYPOMANIC**

☐ **F31.13/296.43-BIPOLAR I DISORDER, MOST RECENT, UNSPECIFIED**

☐ **F31.81/296.89-BIPOLAR II DISORDER**

☐ **F31. / 296. – BIPOLAR 1 DISORDER, CURRENT, MANIC, SEVERE**

☐ **F31. / 296. – BIPOLAR 1 DISORDER, CURRENT, DEPRESSED, SEVERE**

☐ **F31. / 296. – BIPOLAR 1 DISORDER, CURRENT, HYPOMANIC**

☐ **F31. / 296. – BIPOLAR 1 DISORDER, UNSPECIFIED**

☐ **F60.3/301.83- BORDERLINE PERSONALITY DISORDER**

☐ **1. THE INDIVIDUAL DEMONSTRATES IMPAIRED ROLE FUNCTIONING FOR AT LEAST TWO YEARS IN THREE OF THE FOLLOWING CATEGORIES:**

☐ **a. MARKED INABILITY TO ESTABLISH OR MAINTAIN INDEPENDENT COMPETITIVE EMPLOYMENT**
Must Document Clinical Evidence:

☐ **b. MARKED INABILITY TO ESTABLISH OR MAINTAIN PERSONAL SUPPORT SYSTEM**
Must Document Clinical Evidence:

☐ **c. MARKED OR FREQUENT DEFICIENCIES OF CONCENTRATION, PERSISTENCE OR PACE**
Must Document Clinical Evidence:

☐ **d. MARKED INABILITY TO PERFORM OR MAINTAIN SELF-CARE**
Must Document Clinical Evidence:

☐ **e. MARKED DEFICIENCIES IN SELF-DIRECTION**
Must Document Clinical Evidence:

☐ **f. MARKED INABILITY TO PROCURE FINANCIAL ASSISTANCE TO SUPPORT COMMUNITY LIVING**
Must Document Clinical Evidence:

SOCIAL ELEMENTS IMPACTING DIAGNOSIS: *(CHECK ALL THAT APPLY)*

- ☐ NONE
- ☐ PROBLEMS WITH ACCESS TO HEALTH CARE SERVICES
- ☐ HOUSING PROBLEMS (NOT HOMELESS)
- ☐ PROBLEMS RELATED TO SOCIAL ENVIRONMENT
- ☐ EDUCATIONAL PROBLEMS
- ☐ PROBLEMS RELATED TO INTERACTION W/LEGAL SYSTEM
- ☐ OCCUPATIONAL PROBLEMS
- ☐ HOMELESSNESS
- ☐ FINANCIAL PROBLEMS
- ☐ PROBLEMS WITH PRIMARY SUPPORT GROUP
- ☐ OTHER PSYCHOLOGICAL AND ENVIRONMENTAL PROBLEMS
- ☐ UNKNOWN

REASON FOR REFERRAL *(CHECK ALL THAT APPLY):*

☐ EMOTIONAL/MENTAL ILLNESS ☐ EMPLOYMENT INSTABILITY ☐ FINANCIAL INSTABILITY/DIFFICULTY ☐ CPS INVOLVED

☐ BEHAVIOR/CONDUCT PROBLEMS ☐ LEGAL/INCARCERATION ☐ MEDICATION MISMANAGEMENT/MONITORING

☐ PHYSICAL/EMOTIONAL ABUSE ☐ RELATIONAL CONFLICTS ☐ SEXUAL ABUSE ☐ SOCIAL/INTERPERSONAL CHALLENGES

☐ SUBSTANCE ABUSE ☐ SUICIDAL/HOMICIDAL ☐ SCHOOL PROBLEM/SUSPENSION ☐ HOMELESSNESS/AT RISK OF HOMELESSNESS

PRP SERVICES REQUESTED *(CHECK ALL THAT APPLY):*

SELF-CARE SKILLS:

☐ PERSONAL HYGIENE ☐ GROOMING ☐ NUTRITION ☐ DIETARY PLANNING

☐ FOOD PREPARATION ☐ SELF-ADMINISTRATION OF MEDICATION

SOCIAL SKILLS:

☐ COMMUNITY INTEGRATION ACTIVITIES ☐ DEVELOPING NATURAL SUPPORTS

☐ DEVELOPING LINKAGES WITH AND SUPPORTING THE INDIVIDUAL'S PARTICIPATION IN COMMUNITY ACTIVITIES.

INDEPENDENT LIVING SKILLS:

☐ SKILLS NECESSARY FOR HOUSING STABILITY ☐ COMMUNITY AWARENESS ☐ MOBILITY AND TRANSPORTATION SKILLS

☐ MONEY MANAGEMENT ☐ ACCESSING AVAILABLE ENTITLEMENTS AND RESOURCES

☐ HEALTH PROMOTION AND TRAINING ☐ SUPPORTING THE INDIVIDUAL TO OBTAIN AND RETAIN EMPLOYMENT

☐ INDIVIDUAL WELLNESS SELF-MANAGEMENT AND RECOVERY

REASON(S) FOR SEEKING TREATMENT (CHECK ALL THAT APPLY):

☐ LINKAGE TO COMMUNITY RESOURCES/COMMUNITY INTEGRATION

☐ FACILITATING TRANSITION FROM MORE INTENSIVE SERVICES

☐ PREVENTION/REDUCTION OF HOSPITALIZATION OR REHOSPITALIZATION

☐ COORDINATION OF CURRENT COMMUNITY SERVICES

OTHER: _____

LINKED PROVIDERS

PSYCHIATRIST: _____ PHONE NUMBER:_____

THERAPIST: _____ PHONE NUMBER:_____

PRIMARY CARE PROVIDER: _____ PHONE NUMBER : _____

MEDICAL NECESSITY CRITERIA (SELECT ALL THAT APPLY)

THE PARTICIPANT'S MENTAL ILLNESS IS THE CAUSE OF SERIOUS DYSFUNCTION IN ONE OR MORE LIFE DOMAINS,

☐ HOME _ ☐ SCHOOL ☐ COMMUNITY

SYMPTOMS AND BEHAVIOR/RISK BEHAVIORS *(CHECK ALL THAT APPLY):*

☐ ANXIETY/PANIC ☐ ATTACHMENT PROBLEMS ☐ DEPRESSED ☐ FIRE SETTING ☐ HOMICIDAL IDEATIONS
☐ HOPELESS/HELPLESS ☐ HYPERACTIVE ☐ IMPULSIVE ☐ IRRITABLE ☐ ISOLATIVE ☐ LYING/MANIPULATIVE
☐ MANIC MOOD ☐ OBSESSION/COMPULSION ☐ OPPOSITIONAL DEFIANT ☐ PHYSICAL AGGRESSION
☐ PROPERTY DESTRUCTION ☐ RUNNING AWAY ☐ SELF-CARE DEFICIT ☐ SELF-INJURIOUS BEHAVIOR
☐ SEPARATION PROBLEMS ☐ SEXUALLY INAPPROPRIATE ☐ SOCIAL/WITHDRAWAL ☐ STEALING ☐ SUICIDAL IDEATIONS
☐ TRAUMA-RELATED ☐ TRUANCY ☐ VERBAL AGGRESSION ☐ OTHER

PRP CRITERIA- ADULT

☐ THE NATURE OF THE INDIVIDUAL'S FUNCTIONAL IMPAIRMENTS AND/OR SKILLS DEFICITS CAN BE EFFECTIVELY REMEDIATED THROUGH SPECIFIC, FOCUSED SKILLS-TRAINING ACTIVITIES DESIGNED TO DEVELOP AND RESTORE OR MAINTAIN INDEPENDENT LIVING SKILLS TO SUPPORT THE INDIVIDUALS RECOVERY

☐ THE INDIVIDUAL IS CURRENTLY ENGAGED IN OUTPATIENT MENTAL HEALTH TREATMENT

☐ RESIDES IN A RRP (NOT REQUIRED FOR ALL INDIVIDUALS)

☐ THE INDIVIDUAL DOES NOT REQUIRE A MORE INTENSIVE LEVEL OF CARE.

☐ ALL LESS INTENSIVE LEVELS OF TREATMENT HAVE BEEN DETERMINED TO BE UNSAFE OR UNSUCCESSFUL

☐ PEER OR NATURAL SUPPORT ALTERNATIVES HAVE BEEN CONSIDERED OR ATTEMPTED, AND/OR ARE SUFFICFICENT TO MEET THE NEED FOR SPECIFIC, FOCUSED SKILLS TRAINING TO FUNCTION EFFECTIVELY.

REASON FOR REFERRALS (NARRATIVE – PLEASE PROVIDE CLINICAL JUSTIFICATION):

_____

_____

_____

_____

_____

THERAPIST'S NAME: _____ CREDENTIALS: _____

CONTACT NUMBER: _____ EMAIL: _____

ADDRESS:_____

THERAPIST'S SIGNATURE: _____

L4L USE ONLY

DATE RECEIVED:_____FACILITY:_____

REFERRAL ACCEPTED _____ DATE OF INITIAL APPOINTMENT_____

REFERRAL DENIED _____REASON_____

REFERRAL STATUS COMMUNICATED TO _____ DATE _____

INSURANCE AUTHORIZATION NUMBER_____

NUMBER OF AUTHORIZATION VISITS _____

DATES OF AUTHORIZATION FROM: _____ TO: _____

SCHEDULED DIAGNOSTIC INTERVIEW ☐ YES ☐ NO DATE: _____ THERAPIST: _____

DATE ASSIGNED: _____ COUNSELOR: _____

COMMENTS:

_____

_____

_____