Harford County PRP/ADULT
626 Revolution Road
Havre De Grace MD 21078
Phone #: 410-939-8744
Fax #: 410-939- 8748

Upper Bay Counseling and Support Services
ADULT Psychiatric Rehabilitation Program and Health Home Referral

Cecil County PRP/ADULT
200 Booth Street
Elkton MD 21921
Phone#: 410-996-5104
Fax#: 410-996-5197

Client Name: _____MA#: _____DOB:_____ Race: _____

Address: _____Social Security #_____/_____/_____ Phone #_____

I am referring the client for the following services: ☐ ADULT-PRP Day Program ☐ ADULT-PRP-Off-Site Services ☐ Health Home (HH)
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.**
Priority Population Diagnosis- DATE OF DIAGNOSIS: _____

☐ 295.90/F20.9 Schizophrenia
☐ 295.40/F20.81 Schizophreniform Disorder
☐ 295.70/F25.1 Schizoaffective Disorder, Depressive
☐ 298.9/F29 Unspecified Schizophrenia Spectrum and Other Psychotic Disorder
☐ 295.70/F25.0 Schizoaffective Disorder, Bipolar Type
☐ 298.8/F28 Other Specified Schizophrenia Spectrum and Other Psychotic Disorder
☐ 297.1/F22 Delusional Disorder
☐ 296.33/F33.2 MDD, Recurrent Episode, Severe
☐ 296.34/F33.3 MDD, Recurrent, With Psychotic Features
☐ 296.43/F31.13 Bipolar I, Most Recent Manic, Severe
☐ 296.53/F31.4 Bipolar I, Most Recent Depressed, Severe
☐ 296.40/F31.0 Bipolar I, Most Recent Hypomanic
☐ 296.7/F31.9 Bipolar I Disorder, Unspecified
☐ 296.44/F31.2 Bipolar I, Most Recent Manic, with Psychosis
☐ 296.54/F31.5 Bipolar I, Most Recent Depressed, w/o Psychosis
☐ 296.40/F31.9 Bipolar I, Most Recent Hypomanic, Unspecified
☐ 296.89/F31.81 Bipolar II Disorder
☐ 301.83/F60.3 Borderline Personality Disorder
☐ 301.22/F21 Schizotypal Personality Disorder
☐ 296.80/F31.9 Unspecified Bipolar Disorder

Primary Medical Diagnoses: _____

_____

☐**Is person currently living in a Residential Rehab Program? Yes☐ No☐ IF yes please notify program AA and the Billing Department as a U5 authorization request must be done.**

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

This individual has a serious mental illness which has required the intervention of the Public Mental Health System in the last two years:
Yes☐ No☐
PRP Criteria:
☐The consumer has a serious mental health disorder
☐The impairment results in at least one of the following
1. ☐A clear current threat to the individual's ability to manage current living situation
2. ☐An inability to be employed or attend school without support
3. ☐An inability to manage the effects of his/her mental illness

☐The individual's condition requires an integrated program of rehabilitation services to develop and restore independent living skills to support the individual's recovery
Current Medications: _____
Is the individual med compliant: ☐yes ☐no

Presenting Symptoms: Please include HX of SI and HI

_____

_____

Criminal HX- ☐yes ☐no
Reason for Referral:

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.

_____

Most Recent Psychiatric Hospitalization Date

Other Referral Information

Is the individual currently enrolled in SSI/SSDI? ☐yes ☐no
Is the individual eligible for Developmental Disabilities Administration services? ☐yes ☐no
If 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
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
Is the individual in a Maryland State psychiatric facility with a length of stay of more than 3 months who requires RRP upon discharge? ☐yes ☐no

Clinical Information

Is individual currently receiving mental health treatment from a licensed mental health professional? ☐yes ☐no

Name of Treating Licensed Mental Health Professional	Credential	Agency

Referring individual to PRP

Does this person receive remuneration in any form from the PRP? ☐yes ☐no

Duration of current episode of treatment provided to this individual:
☐less than one month ☐2-3months ☐4-6 month's ☐7-12 month's ☐more than 12 months

Current frequency of treatment provided to this individual:
☐At least 1x/week ☐At least 1x/2 weeks ☐At least 1x/month ☐At least 1x/3month ☐At least 1x/6 months

Has this individual received PRP services from at least one other PRP within the past year? ☐yes ☐no

List any additional treating providers:

Name	Credential	Agency
Name	Credential	Agency

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

Mobile Treatment/Assertive Community Treatment (ACT):
☐Not Applicable ☐Currently☐ In past 30 days

Inpatient Psychiatric Treatment:
☐Not Applicable ☐Currently ☐In past 30 days

Residential SUD Treatment Service Level 3.3:
☐Not Applicable ☐Currently ☐In past 30 days

Residential SUD Treatment Service Level 3.5:
☐Not Applicable ☐Currently ☐In past 30 days

Residential SUD Treatment Service Level 3.7:
☐Not Applicable ☐Currently ☐In past 30 days

Mental Health Intensive Outpatient Program (IOP):
☐Not Applicable ☐Currently ☐In past 30 days

Mental Health Partial Hospital Program:
☐Not Applicable ☐Currently☐ In past 30 days

SUD Intensive Outpatient Program (IOP) Level 2.1:
☐Not Applicable ☐Currently ☐In past 30 days

SUD Partial Hospitalization Program (PHP) Level 2.2:
☐Not Applicable☐ Currently ☐In past 30 days

Residential Crisis:
☐Not Applicable ☐Currently ☐In past 30 days

If currently in treatment in one of the services listed above, a written transition plan will be attached to this request:
☐ Not Applicable ☐yes ☐no

Functional Criteria (Functional Criteria only required if the client DOES NOT have SSI/SSDI).

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):
(Check all that apply and list objective evidence in this form, even if other evidence will be attached to this request)

☐ Marked inability to establish or maintain competitive employment

Evidence of marked inability to establish or maintain competitive employment

☐ Marked inability to perform instrumental activities of daily living (i.e.: shopping, meal preparation, laundry, basic housekeeping, medication management, transportation, and money management)

Evidence of marked inability to perform instrumental activities of daily living (i.e.: shopping, meal preparation, laundry, basic housekeeping, medication management, transportation, and money management)

☐ Marked inability to establish/maintain a personal support system

Evidence of marked inability to establish/maintain a personal support system

☐ Deficiencies of concentration/persistence/pace leading to failure to complete tasks

Evidence of deficiencies of concentration/persistence/pace leading to failure to complete tasks

☐ Unable to perform self-care (hygiene, grooming, nutrition, medical care, safety)

Evidence of 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 our goal directed activities

Evidence of marked deficiencies in self-direction shown by inability to plan, initiate, organize and carry our goal directed activities

☐ Marked inability to procure financial assistance to support community living

Evidence of 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
☐ Marked functional impairment has been limited to less than 3 of the above-listed areas
☐ Has demonstrated marked impaired functioning primarily due to a mental illness in at least three of the areas listed above at 2 years
☐ Has demonstrated impaired role functioning primarily due o a mental illness for at least 3 years

Alternative Service and Transition Considerations

☐ Consideration has been given to using peer supports and other informal supports such as family

List attempts and outcomes of any efforts to serve this individual through less formal means such as peer supports or family

☐ Functional impairments can be safely addressed at the PRP level of care

List specific ways in which PRP services are expected to help this individual

Referring Mental Health Professional Signature and Credentials **Date**

Referring Mental Health Professional's Name **Location and Phone Number**

Treating Psychiatrist **Phone** **Treating Therapist** **Phone**

Please direct your referral to the appropriate manager:

Hope for Tomorrow (Harford PRP)
626 Revolution Street
Havre De Grace, Maryland 21078

Share Program (Cecil PRP)
200 Booth Street
Elkton Maryland 21921

Disposition of Referral
☐Accepted ☐Deny

Date of Contact:

Date of Screening:

OPTUM submission and outcome: