8101 Sandy Spring Road, Suite 250, I, J, K

Laurel, MD 20707

P 240.459.8423

F 419.931.9255

www.cmntycare.com

Adult Psychiatric Rehabilitation Program Referral Form

Date: _____Referring Agency/Address: _____

Therapist Name : _____ Licensure Level: _____Phone: _____Fax:_____

Email Address:_____

Consumer Name: _____ Gender: _____DOB:_____Race: _____

Medical Assistance #: _____

Address: _____ Zip: _____Phone: _____

1. **Is the individual currently enrolled in SSI/SSDI? ☐Yes ☐No**
2. **Is the individual eligible for full funding Developmental Disabilities Administration services? ☐Yes ☐No**
3. **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**
4. **Behavioral Diagnosis (*Please use the current DSM V, ICD-10 diagnoses)* _____Date:_____**
   Diagnosis given by: _____ Date: _____
5. **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 Education? ◯Yes ◯No**
6. **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 an individual is eligible for Developmental Disability Services?) ◯Yes ◯No**
7. **Does this person receive remuneration in any form from the PRP? ◯YES ◯NO**
8. **Duration of current episode of treatment provided to this individual:**
   ◯Less than one month ◯2-3months ◯4-6months ◯7-12 months ◯More than 12 months
9. **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 month
10. **Has this individual received PRP services from another PRP service within the past year? ◯Yes ◯No**

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

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- ❑ **Mobile Treatment/Assertive Community Treatment(ACT)**
- ❑ **Inpatient Psychiatric Treatment**
- ❑ **Residential Crisis**
- ❑ **SUD Partial Hospitalization Program(IOP)Level 2.2**
- ❑ **Residential SUD Treatment Service Level 3.3**
- ❑ **Residential SUD Treatment Service Level 3.5**
- ❑ **Residential SUD Treatment Service Level 3.7**
- ❑ **Mental Health Intensive Outpatient Program(IOP)**
- ❑ **Mental Health Partial Hospital Program**
- ❑ **SUD Intensive Outpatient Program(IOP)Level 2.1**

FUNCTIONAL CRITERIA (***Per medical necessity, at least three of the following must be present on a continuing or intermittent basis over the past two years)***

Check all that apply and list objective evidence below:

- ❑ **Marked inability to establish or maintain competitive employment.**
- ❑ **Marked inability to perform instrumental activities of daily living (eg. Shopping,meal preparation,laundry,medication management).**
- ❑ **Marked inability to establish/maintain a personal support system.**
- ❑ **Deficiencies of concentration/persistence/pace leading to failure to complete tasks.**
- ❑ **Unable to perform self care.**
- ❑ **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 IMPAIRMENTS:

- ❑ **Marked functional impairment has been present for less than 2years.**
- ❑ **Marked functional impairment has been limited to less than 3 of the above listed areas.**
- ❑ **Has demonstrated marked impairment functioning primarily due to mental illness in at least three of the areas listed above at least 1-2years.**
- ❑ **Has demonstrated impaired role functioning primarily due to a mental illness for at least 3 years.**

ALTERNATIVE SERVICE AND TRANSITION CONSIDERATION:

- **Consideration has been given to using peer supports and other information supports such a family.**
  List attempts and outcomes of any efforts to serve this individual through less formal means such as peer supports or family: _____
-

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- **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:**

  _____

  _____

COLLABORATION AGREEMENT

I, _____ (*Therapist Name and Title*), agree to participate in team treatment planning sessions/initial session within two weeks of receipt of the referral and quarterly sessions in person or by phone.

Therapist Signature: _____ Date: _____

For Community Care, LLC Staff Only
Date Referral Received: _____ Received By: _____