Psychiatric **R**ehabilitation **P**rogram (**PRP**)
REFERRAL and RELEASE OF INFORMATION

Name:_____AGE: _____

Date of Birth _____/_____/_____ Grade: _____

School (if applicable) _____

Address: _____APT #: _____

_____

_____
Guardian's Name (if applicable)

Home Phone: (_____) _____-_____

Guardian Cellular: (_____) _____-_____

Guardian Work: (_____) _____-_____

Client Cellular: (_____) _____-_____

Consumer MA: _____

Referring Agency:_____ Name of Agency Contact: _____

Agency Referral Phone: ( ) _____ - _____ Contact Email: _____

Consent to Services:
I understand that I am applying for mental health services for the Psychiatric Rehabilitation Program of the Worcester County Health Department. I agree to receive these services if approved and to participate in the development of a Treatment Plan, which I will be asked to sign. I understand that I may revoke my consent to services at any time by written or verbal request.

Information Release:
I authorize the above referenced referring provider to furnish to the Worcester County Health Department, the information requested on the Psychiatric Rehabilitation Program Pre-screening and the Psychiatric Rehabilitation Program forms for review. This information will be used to make a pre-determination of eligibility for Psychiatric Rehabilitation Program services. As part of pre-determination of eligibility, I further authorize the Worcester County Health Department to contact other agencies from which I might be receiving services. If found eligible for services, I further authorize the release of this information to the Worcester County Health Department's Psychiatric Rehabilitation Program for full screening and service eligibility determination and to Optum, to determine eligibility for Psychiatric Rehabilitation services. I understand that I may revoke my permission at any time by written or verbal request.

Consumer Signature (or guardian):_____ Date: _____

Witness: _____ Date: _____

Psychiatrist's Signature_____ Date: _____
(only needed if active with Psychiatrist):

Clinician's Signature: _____ Date: _____

Date of last clinical evaluation: _____ Diagnosing Clinician: _____, _____
(Please include credentials)

*Referring individual will be required to participate in a phone call with the PRP provider to determine eligibility.

PSYCHIATRIC REHABILITATION PROGRAM
ADULT PRE-SCREENING

	YES	NO
ADULTS ARE IDEALLY SEEN 6 TIMES PER MONTH. IS THERE ANYTHING THAT WOULD PREVENT THE CONSUMER FROM BEING SEEN THIS AMOUNT OF TIMES PER MONTH?	☐	☐
IS THE CONSUMER WILLING TO PARTICIPATE IN GROUP SERVICES?	☐	☐
ARE THE CONSUMER'S BASIC NEEDS BEING MET AT THIS TIME (FOOD, HOUSING, MAINTAINING BILLS)? *IF NOT, THE CONSUMER MAY BE BETTER SERVED BY OUR TARGETED CASE MANAGEMENT PROGRAM.	☐	☐

ELIGIBILITY CRITERIA PLEASE CHECK ☐ ALL THAT APPLY:

ADULTS MUST HAVE AT LEAST ONE OF THE FOLLOWING DIAGNOSES:

CAT A	☐ F20.81	SCHIZOPHRENIFORM DISORDER
	☐ F20.9	SCHIZOPHRENIA
	☐ F22	DELUSIONAL DISORDER
	☐ F25.0	SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE
	☐ F25.1	SCHIZOAFFECTIVE DISORDER, DEPRESSIVE TYPE
	☐ F28	OTHER SPECIFIED SCHIZOPHRENIA SPECTRUM AND OTHER PSYCHOTIC DISORDER
	☐ F29	UNSPECIFIED SCHIZOPHRENIA SPECTRUM AND OTHER PSYCHOTIC DISORDER
	☐ F31.2	BIPOLAR I DISORDER, CURRENT OR MOST RECENT EPISODE MANIC, SEVERE, WITH PSYCHOTIC FEATURES
	☐ F31.5	BIPOLAR I DISORDER, MOST RECENT EPISODE DEPRESSED, WITH PSYCHOTIC FEATURES
	☐ F33.3	MAJOR DEPRESSIVE DISORDER, RECURRENT EPISODE, WITH PSYCHOTIC FEATURES

CAT B	☐ F31.0	BIPOLAR I DISORDER, CURRENT OR MOST RECENT EPISODE HYPOMANIC
	☐ F31.13	BIPOLAR I DISORDER, CURRENT OR MOST RECENT EPISODE MANIC, SEVERE
	☐ F31.4	BIPOLAR I DISORDER, CURRENT OR MOST RECENT EPISODE DEPRESSED, SEVERE
	☐ F31.81	BIPOLAR II DISORDER
	☐ F31.9	BIPOLAR I DISORDER, CURRENT OR MOST RECENT EPISODE HYPOMANIC, UNSPECIFIED BIPOLAR I DISORDER, CURRENT OR MOST RECENT EPISODE UNSPECIFIED
	☐ F33.2	MAJOR DEPRESSIVE DISORDER, RECURRENT EPISODE, SEVERE
	☐ F60.3	BORDERLINE PERSONALITY DISORDER

OTHER REFERRAL INFORMATION:	YES	NO
HAS THE CLIENT BEEN FOUND NOT COMPETENT TO STAND TRIAL OR NOT CRIMINALLY RESPONSIBLE AND IS RECEIVING SERVICES RECOMMENDED BY A MARYLAND DEPARTMENT OF HEALTH EVALUATOR?	☐	☐
IS THE CLIENT IN A MARYLAND STATE PSYCHIATRIC FACILITY WITH A LENGTH OF STAY OF MORE THAN 3 MONTHS WHO REQUIRES RRP UPON DISCHARGE?	☐	☐
IS THE CLIENT ELIGIBLE FOR FULL FUNDING FOR DDA SERVICES?	☐	☐
IS THE PRIMARY REASON FOR IMPAIRMENT DUE TO THE FOLLOWING: ORGANIC PROCESS OR SYNDROME: INTELLECTUAL DISABILITY, NEURODEVELOPMENTAL DISORDER OR NEUROCOGNITIVE DISORDER?	☐	☐

1. THERAPIST (INCLUDE CREDENTIALS, IF LMSW OR LGPC PLEASE INCLUDE SUPERVISOR'S INFO)

_____

NAME / CREDENTIALS

2. DOES THIS PERSON RECEIVE REMUNERATION IN ANY FORM FROM THE PRP?

- ☐ YES
- ☐ NO

3. DURATION OF CURRENT EPISODE OF TREATMENT PROVIDED TO THE CLIENT (PLEASE CHECK ONE):

- ☐ LESS THAN ONE MONTH
- ☐ MORE THAN 12 MONTHS
- ☐ 2-3 MONTHS
- ☐ 4-6 MONTHS
- ☐ 7-12 MONTHS

4. CURRENT FREQUENCY OF TREATMENT PROVIDED TO THIS CLIENT (PLEASE CHECK ONE):

- ☐ AT LEAST 1X/WEEK
- ☐ AT LEAST 1X/2 WEEKS
- ☐ AT LEAST 1X/MONTH
- ☐ AT LEAST 1X/3 MONTHS
- ☐ AT LEAST 1X/6 MONTHS

5. HAS THIS CLIENT RECEIVED PRP SERVICES FROM AT LEAST ONE OTHER PRP WITHIN THE PAST YEAR?

- ☐ YES
- ☐ NO

6. PLEASE LIST ANY OTHER TREATING PROVIDERS:

PCP: _____

NAME/CREDENTIALS/AGENCY

_____

NAME/CREDENTIALS/AGENCY

CLINICAL INFORMATION:

7. OTHER SERVICE INVOLVEMENT:

N/A	CURRENTLY	IN PAST 30 DAYS	
☐	☐	☐	MOBILE TREATMENT/ASSERTIVE COMMUNITY TREATMENT (ACT)
☐	☐	☐	INPATIENT PSYCHIATRIC TREATMENT
☐	☐	☐	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)
☐	☐	☐	SUD PARTIAL HOSPITALIZATION PROGRAM (PHP) LEVEL 2.2
☐	☐	☐	RESIDENTIAL CRISIS
☐	☐	☐	TARGETED CASE MANAGEMENT
☐	☐	☐	MH-RESIDENTIAL TREATMENT CENTER (RTC)
☐	☐	☐	IF CURRENTLY IN TREATMENT IN ONE OF THE ABOVE, A WRITTEN TRANSITION PLAN WILL BE ATTACHED TO THIS REQUEST
☐	☐	☐	CLIENT PARTICIPATED IN A SELF-HELP GROUP IN THE LAST 30 DAYS? IF YES, HOW MANY?

8. FUNCTIONAL CRITERIA (Select THREE criteria and please explain how the primary mental health diagnosis hinders client's ability to perform or complete selected criteria):

☐ MARKED INABILITY TO ESTABLISH OR MAINTAIN COMPETITIVE EMPLOYMENT

☐ MARKED INABILITY TO PERFORM INSTRUMENTAL ACTIVITIES OF DAILY LIVING (E.G. SHOPPING, MEAL PREPARATION, LAUNDRY, BASIC HOUSEKEEPING, MEDICATION MANAGEMENT, TRANSPORTATION AND MONEY MANAGEMENT)

☐ MARKED INABILITY TO ESTABLISH A PERSONAL SUPPORT SYSTEM

☐ DEFICIENCIES OF CONCENTRATION/PERSISTENCE/PACE LEADING TO FAILURE TO COMPLETE TASKS

☐ 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

9. CAN THE PARTICIPANT'S FUNCTIONAL IMPAIRMENTS BE SAFELY ADDRESSED AT THE PRP LEVEL OF CARE?

☐ YES
☐ NO

10. DURATION OF IMPAIRMENTS:

YES NO

☐ ☐ HAS THE CLIENT'S MARKED FUNCTIONAL IMPAIRMENT BEEN PRESENT FOR LESS THAN 2 YEARS?
IF YES, DOES PARTICIPANT HAVE A NEW ONSET (WITHIN PAST 6 MONTHS, CATEGORY A DX)?
☐ YES
☐ NO

11. HAS THE CLIENT DEMONSTRATED MARKED IMPAIRED FUNCTIONING PRIMARILY DUE TO A MENTAL ILLNESS IN AT LEAST 3 FUNCTIONAL CRITERIA FOR AT LEAST 2 YEARS? (SEE QUESTION #8)

☐ YES
☐ NO

12. ALTERNATIVE SERVICE AND TRANSITION CONSIDERATIONS: HAS CONSIDERATION BEEN GIVEN TO USING PEER SUPPORTS AND OTHER INFORMAL SUPPORTS SUCH AS FAMILY?

☐ YES (PLEASE EXPLAIN)
☐ NO

13. **EXAMPLE OF ADULT NARRATIVE:**

CLIENT IS EXPERIENCING INCREASED SYMPTOMS RELATED TO THEIR PTSD (FLASHBACKS, HYPERVIGILANCE, AND AVOIDANCE) AND HAS BEEN ISOLATING THEMSELVES IN THEIR APARTMENT. CLIENT IS EXPERIENCING CRYING SPELLS AND PANIC ATTACKS MULTIPLE TIMES A WEEK. CLIENT HAS MINIMAL TO NO SOCIALIZATION AT THE CURRENT TIME AND WOULD BENEFIT FROM PRP TO INCREASE THEIR SOCIAL OUTLETS. PRP COULD ASSIST IN AIDING THEM IN SOCIALIZATION SKILLS AND COPING SKILLS TO DEAL WITH CURRENT STRESSORS.

PLEASE INDICATE HOW PRP WILL BENEFIT THIS CLIENT: PLEASE WRITE YOUR NARRATIVE HERE:

14. PRP WORKER SAFETY:

☐ IS IT RECOMMENDED THAT CONSUMER BE SEEN AT THE CLINIC INSTEAD OF THE HOME DUE TO SAFETY?

IF SELECTED, EXPLAIN:

15. HIGHEST GRADE LEVEL OF SCHOOL COMPLETED? _____

16. DISABILITY STATUS:

	CHECK ONE: YES	NO	N/A
IS THE CONSUMER DEAF OR DO THEY HAVE SERIOUS DIFFICULTY HEARING?	☐	☐	☐
IS THE CONSUMER BLIND OR DO THEY HAVE SERIOUS DIFFICULTY SEEING, EVEN WHEN WEARING GLASSES?	☐	☐	☐
BECAUSE OF A PHYSICAL, MENTAL OR EMOTIONAL CONDITION, DOES THE CONSUMER HAVE SERIOUS DIFFICULTY CONCENTRATING, REMEMBERING OR MAKING DECISIONS?	☐	☐	☐
DOES THE CONSUMER HAVE SERIOUS DIFFICULTY WALKING OR CLIMBING STAIRS? (AGE 5 OR OLDER)	☐	☐	☐
BECAUSE OF A PHYSICAL, MENTAL, OR EMOTIONAL CONDITION, DOES THE CONSUMER HAVE DIFFICULTY DOING ERRANDS ALONE SUCH AS VISITING A DOCTOR'S OFFICE OR SHOPPING? (AGE 15 OR OLDER)	☐	☐	☐
DOES THE CONSUMER HAVE DIFFICULTY DRESSING OR BATHING? (AGE 5 OR OLDER)	☐	☐	☐
DOES THE CONSUMER CURRENTLY RECEIVE SSI OR SSDI	☐	☐	☐

17. WHO DOES CONSUMER LIVE WITH? _____

18. PRIMARY SOURCE OF INCOME: _____

19. TOBACCO USE IN THE PAST 30 DAYS?
- ☐ YES
- ☐ NO

20. DOES CLIENT SMOKE CIGARETTES?
- ☐ YES
- ☐ NO

21. HAS CLIENT PARTICIPATED IN A SELF-HELP GROUP IN THE LAST 30 DAYS?
- ☐ YES (IF YES, NUMBER OF TIMES IN SELF-HELP GROUP IN THE PAST 30 DAYS _____)
- ☐ NO

22. SUBSTANCE ABUSE HISTORY:

IS THERE A HISTORY OF SUBSTANCE ABUSE?
- ☐ YES
- ☐ NO

INVOLVED IN SUBSTANCE ABUSE TREATMENT?
- ☐ YES
- ☐ NO

IF YES, PLEASE PROVIDE THE FOLLOWING INFORMATION:

A. PRIMARY SUBSTANCE USED _____
AGE OF FIRST USE _____
ROUTE OF ADMINISTRATION _____
FREQUENCY OF USE _____
DATE LAST USED _____

B. SECONDARY SUBSTANCE USED _____
AGE OF FIRST USE _____
ROUTE OF ADMINISTRATION _____
FREQUENCY OF USE _____
DATE LAST USED _____