Adult PRP Referral Form

☐**Initial** ☐**Concurrent**

Name of Referral Source ***(Please include credentials):***	**Date of Referral:**
NPI:	**Agency:**
Phone:	**Email:**
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:**	English		
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	CATEGORY B (If box is checked, answer questions below)
☐ 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	☐ 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

☐ F33.3 MDD, Recurrent, With Psychotic Features	

Is the participant currently enrolled in SSI/SSDI? ___ Yes ___ No

Is the participant eligible for full funding for DDA services? __ Yes __ No

Is the primary reason for the participant's impairment due to an organic process or syndrome, intellectual disability, a neurodevelopmental disorder or neurocognitive disorder? __ Yes __ No

Has the participant been found not competent to stand trial or not criminally responsible and is receiving services recommended by a MDH Evaluator? __ Yes __ No

Is the participant in a Maryland State psychiatric facility with a length of stay of more than 3 months who requires RRP upon discharge? (select No if participant is eligible for DDS) ___ Yes ___ No

Is the participant on medication? __ Yes ___ No; If no, why are medications not part of the treatment? _____

_____

Clinical Information:

Participant is being referred from __IP/Crisis __ Res/Mobile/ACT/Incarceration __ Outpatient __ Neither

Is the participant currently receiving MH treatment from a licensed mental health provider? __ Y __N

Is the licensed mental health provider enrolled as a provider in the Medicaid program? __ Y __ N

Is the referral source in some way paid for by or receiving other benefits from the PRP program? __ Y __ N

Duration of current episode of treatment: _____

Current frequency of outpatient clinical treatment: _____

Why is ongoing outpatient treatment not sufficient to address concerns?

If the participant is currently in treatment or receiving services from one of the services listed below, attach a transition plan with your submission or explain why both services are needed.

Mobile Treatment/ ACT
Targeted Case Management
Inpatient
MH-RTC
Residential Crisis

SUD Level 3.3, 3.5, 3.7, 3.7WM
SUD IOP
SUD PHP
MH IOP
MH PHP

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Have any of the following less intensive levels of treatment been tried? If yes, explain why they have not been sufficient. If not, what is the reason it has not been tried?

Peer or other informal supports: __ Y __ N Group Therapy: __N __ Y Targeted Case Management:

__ Y __ N

Explanation:

Functional Criteria

Does the participant have a new onset (within the past 6 months) diagnosis? __ Y __ N

Has participants had impairments related to the Priority Population diagnosis in 3 or more of the functional areas listed below over the last 2 years? __ Y __ N

Check all that apply and list objective evidence, including **description of the symptoms, how they impair functioning, & concrete examples of the participant's impaired function**.

__ Marked inability to establish or maintain competitive employment

Evidence:

__ Marked inability to perform instrumental activities of daily living (e.g. shopping, meal prep, laundry, basic housekeeping, medication management, transportation, money management)

Evidence:

__ Marked inability to establish/maintain a personal support system

Evidence:

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

Evidence:

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

Evidence:

__ Marked deficiencies in self-direction, shown by inability to plan, initiate, organize & carry out goal-directed activities

Evidence:

__ Marked inability to procure financial assistance to support community living

Evidence:

******Your signature hereunder confirms your professional endorsement that ongoing PRP interventions remain essential and that, per your clinical judgment, these services are medically necessary for the promotion of the individual's holistic health and rehabilitative progress.******

Clinician Signature and Credentials: _____ Date: _____

Supervisor Signature and Credentials (*If applicable):* _____

Supervisor NPI: _____