Child/Adolescent 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				

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

Will the participant's level of cognitive impairment, current mental status or developmental level impact their ability to benefit from PRP? __ Yes ___ No

Does the participant meet criteria for a higher level of care than PRP? ___ Yes ___ No

Have family or peer supporters been successful in supporting this youth? __ Yes ___ No

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

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Clinical Information:

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

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

Current frequency of outpatient clinical treatment: _____

How long has the participant been engaged in active, documented outpatient treatment? _____

In the past 3 months, how many ER visits has the youth had for psychiatric care? _____

Is the participant transitioning from an inpatient, day hospital or residential treatment setting to a community setting? __ Y __ N

Does the participant have a Targeted Case Management referral or authorization: __ Y __ N

Has medication been considered for this participant? __ Not considered __ Considered and Ruled Out

__ Ongoing __ Initiated and Discontinued

Functional Criteria

Within the past 3 months, the emotional disturbance has resulted in: (*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***.)

__ A clear, current threat to the participant's ability to be maintained in their customary setting.

Evidence:

__An emerging risk to the safety of the participant or others.

Evidence:

__ Significant psychological or social impairments causing serious problems with peer relationships and/or family members

Evidence:

What evidence exists to show that the current intensity of outpatient treatment is insufficient to reduce symptoms and functional behavioral impairments resulting from mental illness?:

Evidence:

Has a crisis plan been completed with family and/or guardians? __ Y __ N

Has an individual treatment plan / individual rehabilitation plan been completed? __ Y __ N

For initial requests: How will PRP serve to help this participant get to age appropriate development, more independent functioning and independent living skills?:

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For concurrent requests: Has the youth made progress toward age appropriate development, more independent functioning and independent living skills? __ Y __ N

If yes, describe the improvement:

If no, describe changes to the treatment plan to address the lack of progress:

******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: _____