



**Hands Across Baltimore, LLC**

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Child & Adolescent Psychiatric Rehabilitation Program (PRP) Referral

**Client Demographics**

Name:	Date of Birth:	Age:	Gender:	Ethnicity:
Address:	City/State/Zip Code:	Marital Status:	Social Security Number:	
Legal Parent/Guardian:	Phone:	Email:	Participant Medicaid Number:	

1. Is the participant eligible for full funding for DDA services? Yes  No
2. 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
3. Will the participant's level of cognitive impairment, current mental status or developmental level impact their ability to benefit from PRP? Yes  No
4. Does the participant meet criteria for a higher level of care than PRP? Yes  No
5. Have family or peer supports been successful in supporting this youth? Yes  No

**Referring Source Information**

Agency Name:	Agency Phone Number:
Agency Address:	

Is participant currently receiving mental health outpatient or inpatient treatment? Yes  No

**Treating Provider Information**

**\*Note\*** If you are completing this referral and do not have the following licensure, you **must** have your Supervising Clinician sign this referral as well!  
*MD/DO, PhD/PsyD, LCSW-C, LCPC, LCMFT, APRN-PMH/CRNP-PMH, LCADC or LCPAT*

Provider's Full Name & Credentials:	Provider's Phone Number:
Provider's Email Address:	
Provider's NPI #:	

### Clinical Information

1. Is the referral source in some way paid by or receiving other benefits from the PRP Program? Yes  No
2. Current frequency of treatment being provided to this participant?  
 1x per week       1x every 2 weeks  
 1x a month       1x every 6 months
3. How long has the participant been engaged in active, documented, outpatient therapy?  
 Less than 1 month       4-6 months  
 2-3 months       6 months or more
4. In the past 3 months, how many ER visits has the participant had for care ER visits for psychiatric care?  
 None       1       2 or more
5. Is the participant transitioning from an inpatient, day hospital or residential treatment setting to a community setting? Yes  No
6. Does the participant have a Targeted Case Management referral or authorization? Yes  No
7. Has medication been considered for this client?  
 Ongoing       Initiated and withdrawn  
 Not Considered       Considered and ruled out

### DSM-V Diagnosis

Diagnostic Category:	Code:	Description:
Diagnostic Category:	Code:	Description:
Diagnostic Category:	Code:	Description:

### Social Elements Impacting Diagnosis

- None
- Unknown
- Financial Problems
- Homelessness
- Problems with Access to Health Care Services
- Medical Disabilities That Impact Diagnosis or Must Be Accommodated for In Treatment
- Problems Related to Interaction w/ Legal System/ Crime
- Problems with Primary Support Group
- Problems Related to the Social Environment
- Housing Problems (Not Homelessness)
- Occupational Problems
- Educational Problems
- Other Psychosocial and Environmental Problems

### Functional Criteria

**\*Note\*** List at least 3 things that the participant struggles with and include objective evidence of how this behavior is displayed.

1. **Within the past three months, the individual's emotional disturbances have resulted in:**

- a. A clear current threat to the youth's ability to be maintained in their customary setting?  Yes  No

If yes, please provide objective evidence of a clear, current threat to the participants ability to be maintained in their customary setting.

b. An emerging risk to the safety of the youth or others? Yes  No

If yes, please provide evidence of an emerging risk to the safety of the participant or others.

c. Significant psychological or social impairments causing serious problems with peer relationships and/ or family members? Yes  No

If yes, please provide evidence of the psychological or social impairments causing serious problems with peer relationships and/or family members.

2. What evidence exists to show that the current intensity of outpatient treatment for this individual is insufficient to reduce the youth's symptoms and functional behavior impairments resulting from mental illness?

3. Has a crisis plan been completed with family and/or guardian?      Yes       No

**For Initial Requests**

1. How will PRP serve to help this participant get to age appropriate development, more independent functioning and independent living skills?

### For Concurrent Request

1. Has the youth made progress toward age-appropriate development, more independent functioning, and independent living skills? Yes  No

If **yes**, please describe the improvement.

If **no**, indicate the changes in treatment plan to address the lack of progress.

### Signature

Provider's Full Name and Credentials:

Supervising Clinician Full Name and Credentials (if applicable):

Date of Referral: