



Adult 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 participant currently enrolled in SSI / SSDI? Yes  No
3. 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
4. Has the participant been found incompetent to stand trial or not criminally responsible and is receiving services recommended by a MDH Evaluator? Yes  No
5. 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 the participant is eligible for DDS) Yes  No
6. Is the participant on medication? Yes  No  **If no, why are medications not part of the treatment?**

7. Participant is being referred from:
  - IP/Crisis Res/Mobile/ACT/Incarceration
  - Outpatient
  - Neither

8. Is the participant currently receiving MH treatment from a licensed health provider? Yes  No

9. Is the licensed mental health provider enrolled as a provider in the Medicaid program? Yes  No

### Referring Source Information

Agency Name:	Agency Phone Number:
Agency Address:	

### 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 outpatient clinical treatment?

<input type="checkbox"/> 1x per week	<input type="checkbox"/> 1x every 2 weeks
<input type="checkbox"/> 1x a month	<input type="checkbox"/> 1x every 6 months

3. Duration of current episode of treatment?

<input type="checkbox"/> Less than 1 month	<input type="checkbox"/> 4-6 months
<input type="checkbox"/> 2-3 months	<input type="checkbox"/> 6 months or more

4. Why is ongoing outpatient treatment not sufficient to address concerns?

5. 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 Services (MTS)/ \*Assertive Community Treatment (ACT)
- Targeted Case Management
- Inpatient
- MH-RTC
- SUD Level 3.3, 3.5, 3.7, 3.7WM
- SUD IOP
- SUD PHP
- MH IOP
- MH PHP Residential Crisis

6. Have any of the following less intensive levels of treatment been tried? **If yes**, explain why they have not been sufficient. **If no**, what is the reason it has not been tried?

- Group Therapy: Yes  No

- Peer or other informal supports: Yes  No

- Targeted Case Management: Yes  No

### Diagnostic Information

Please enter the client's primary diagnosis

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

### Functional Criteria

Does the participant have a new onset (within past 6 months) diagnosis? Yes  No

Has the participant had impairments related to the Priority Population diagnosis in **3 or more** of the functional areas listed below over the last 2 years? Yes  No

**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:

Signature

Provider's Full Name and Credentials:

Supervising Clinician Full Name and Credentials (if applicable):

Date of Referral: