

**Instructions:** Please PRINT and fax (cover not required) completed form to 1-800-372-0799, or email to: referral@AdvocateSupport.us

**Information about the individual being referred.**

First name, MI, Last Name	Date of Birth
Home address (number, street, and apartment number)	Phone Number
City, state, and ZIP code	Maryland Medical Assistance, MA, or Medicaid #
Psychiatrist Name/Organization	Social Security Number
Psychiatrist address (number, street, and suite number)	Psychiatrist Phone Number
Psychiatrist city, state, and ZIP code	Psychiatrist Fax Number

**Diagnoses:** Individuals must have a MHA approved Axis I diagnosis to qualify for PRP services in Maryland. (see back for list)

<b>Axis I</b>	
<b>Axis II</b>	
<b>Axis III</b>	
<b>Axis IV</b>	
<b>Axis V</b>	Diagnoses made by: _____ Date: _____

<b>Presenting Problems, Current Symptoms &amp; Additional Information</b> Briefly describe individual's current problems, symptoms and needs for community support. Include any information that you feel will assist in determining eligibility and admission into Advocate's PRP.	<b>Services Needed</b> Individual needs assistance with: (select all that apply)
	<input type="checkbox"/> Self Care Skills <input type="checkbox"/> Social Skills <input type="checkbox"/> Independent Living Skills <input type="checkbox"/> Cultural Development <input type="checkbox"/> Medication <input type="checkbox"/> Health Promotion & Training <input type="checkbox"/> Housing <input type="checkbox"/> Appointment Management <input type="checkbox"/> Medical/Somatic <input type="checkbox"/> Substance Abuse Issues <input type="checkbox"/> Linkage/Accessing Other Services <input type="checkbox"/> Legal Issues

**Referral Source Information**

Your name and credentials	Phone Number
Organization	Fax Number
Address (number, street, suite number, city, state, and ZIP code)	Email

I am referring this individual to receive Psychiatric Rehabilitation Services from Advocate Support Services. I believe that there is a reasonable expectation that these services will help this individual to improve and/or maintain independence and current functional level in the community.

Referral Source Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Priority Population – Adults**  
**SEVERELY MENTALLY ILL**  
**PRIORITY POPULATION DEFINITION - ADULTS (SMI)**  
**Revised 9/1/03, 3/10/14, 7/8/14, 8/26/20, 1/12/21**

**INCLUDED DIAGNOSES ICD-10 diagnosis codes:**

F20.0 Paranoid Schizophrenia  
F20.1 Disorganized Schizophrenia  
F20.2 Catatonic Schizophrenia  
F20.3 Undifferentiated schizophrenia  
F20.5 Residual schizophrenia  
F20.81 Schizophreniform Disorder  
F20.89 Other schizophrenia  
F20.9 Schizophrenia, unspecified  
F22 Delusional Disorders  
F25.0 Schizoaffective Disorder, Bipolar Type  
F25.1 Schizoaffective Disorder, Depressive Type  
F25.8 Other Schizoaffective Disorders  
F25.9 Schizoaffective Disorder, unspecified  
F28 Other Specified Schizophrenia Spectrum and Other Psychotic Disorder  
F29 Unspecified Schizophrenia Spectrum and Other Psychotic Disorder  
F31.0 Bipolar I Disorder, Current or Most Recent Episode Hypomanic  
F31.13 Bipolar I Disorder, Current or Most Recent Episode Manic, Severe  
F31.2 Bipolar I Disorder, Current or Most Recent Episode Manic, With Psychotic Features  
F31.4 Bipolar I Disorder, Current or Most Recent Episode Depressed, Severe  
F31.5 Bipolar I Disorder, Most Recent Episode Depressed, With Psychotic Features  
F31.63 Bipolar I Disorder, Mixed, Severe, Without Psychotic Features  
F31.64 Bipolar I Disorder, Mixed, Severe With Psychotic Features  
F31.81 Bipolar II Disorder  
F31.9 Bipolar I Disorder, Unspecified  
F33.2 Major Depressive Disorder, Recurrent Episode, Severe  
F33.3 Major Depressive Disorder, Recurrent Episode, With Psychotic Features  
F60.3 Borderline Personality Disorder

***-and-***

In order to be included in the PRIORITY POPULATION, individuals must meet the target diagnostic criteria and meet the following functional limitations:

Serious mental illness is characterized by impaired role functioning, on a continuing or intermittent basis, for at least two years, including at least three of the following:

- Inability to maintain independent employment,
- Social behavior that results in interventions by the mental health system,
- Inability, due to cognitive disorganization, to procure financial assistance to support living in the community,
- Severe inability to establish or maintain a personal support system, or
- Need for assistance with basic living skills.