

**Please complete the following concurrent referral to its entirety.**

MD regulations require our clients to have this form completed 2x annually, minimum, for continued PRP services.

Currently Serving: Anne Arundel County, Baltimore County, Baltimore City, Howard County, & Prince George's County.

Information about the individual being referred	Referral Source Information Psychiatrist or Licensed Mental Health Provider
First Name, MI, Last Name	Your Name and Credentials
Date of Birth	Organization Name
Active MD Medicaid Number	Address (number, street, suite number, city, state, zip)
Home Address (number, street, apt., city, state, zip)	Phone Number
Phone Number	Fax Number
<b>Psychiatric Rehabilitation Program Accepted Primary Dx</b> F20.0 F20.1 F20.2 F20.3 F20.5 F20.81 F20.89 F20.9 F22 F25.0 F25.1 F25.8 F25.9 F28 F29 F31.0 F31.13 F31.2 F31.4 F31.5 F31.63 F31.64 F31.81 F31.9 F33.2 F33.3 F60.3	Email
Primary ICD-10 Diagnosis Code, Fully written:	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. <b>Accepted Credentials: APRN-PMH, CRNP-PMH, LCADC, LCMFT, LCPAT, LCPC, LCSW-C, MD, DO, PhD, PsyD, LMSW, LGSW, LGPC, LGADC, LGMFT, LGPAT</b>
Changes and/or Additional Diagnoses:	Referral Source Signature
<b>Why is PRP being recommended in addition to outpatient mental health treatment/modalities?</b> This section is mandatory from the provider for PRP eligibility. Briefly describe the individuals current problems, symptoms, and needs for community support.	Credentials
	National Provider Identifier (NPI) <b>with Active Medicaid</b>
	Date
	This box is only necessary if signing referral source credentials are: LMSW, LGSW, LGPC, LGADC, LGMFT or LGPAT - Please list supervisor's Name & Credentials

**Thank you for entrusting us with support of this referred client.**