Treatment Referral:					
Client Name:		**Date of Referral:**		**Requested Date of Assessment:**	
Current Address:					
Date of Birth:		**Gender Preference:**		**Marital Status:**	
Phone Number:		**Email Address:**			
Insurance:		**Policy or MA#**			

FOR PRP ONLY			
Referral Source:			
Referral Source Name:		**Referral Source Phone #:**	
Referral Source Credentials		**Referral Source Address:**	
Is the individual currently receiving any of the following services:	☐ MOBILE TREATMENT SERVICES ☐ ASSERTIVE COMMUNITY TREATMENT (ACT) ☐ ADULT TARGETED CASE MANAGEMENT (TCM) ☐ INPATIENT METAL HEALTH -RESIDENTIAL TREATMENT CENTER (RTC) ☐ RESIDENTIAL SUD TREATMENT LEVEL 3.3 AND HIGHER SUBSTANCE USE DISORDER ☐ INTENSIVE OUTPATIENT/2.1 ☐ MENTAL HEALTH INTENSIVE OUTPATIENT / PARTIAL HOSPITALIZATION PROGRAM ☐ RESIDENTIAL CRISIS SERVICES ☐ NONE		

ALL REFERRALS	
Current Diagnosis: Please indicate the current ICD-10 Codes:	
Reason for Referral: ***(Please explain how the client's diagnosis is a barrier for community integration)***	
Frequency & Severity of Issue:	
Recent Hospitalizations:	
Lethality or Safety Issues	
Relevant Medical Diagnosis:	

Current Medication		
Name of Medication	**Dosage**	**Frequency**

Accommodations:	☐ TTY ☐ Interpreter ☐ Sign Language ☐ Ambulatory Limitations ☐ Other ☐ None
Is the client currently receiving services with another provider?	☐ Yes ☐ No If yes please list the name of the organization and the dates of services
Referral Source Signature:	
Referral Source Printed Name:	
Master's or Graduate Level Supervisor Name if Applicable	
Date:	

MEDICAL NECESSITY CRITERIA
Psychiatric Rehabilitation Program Services (PRP)

_____ _____
Name of Client **Referring Clinician Signature**

_____ _____
Diagnosis **Date**

FACTORS OR CRITERIA JUSTIFYING THE NEED FOR PRP SERVICES

The client's mental illness is the cause of serious dysfunction in one or more life domains (home, school, community). Please cite examples of dysfunction in one or more life domains.

_____
_____
_____
_____

Based on the clinical evaluation and ongoing treatment plan, PRP services are indicated and are expected to reduce the symptoms of the client's mental illness or the functional behavioral impairment that is a result of the mental illness.

The impairment as a result of the client's mental illness results in: (Please check all that apply)

☐ A clear, current threat to the individual's ability to be maintained in his or her customary setting, or

☐ An emerging/pending risk to the safety of the individual or others, or

☐ Other evidences of significant psychological or social impairment such as inappropriate social behavior causing serious problems with peer relationships and/or family members.

☐ Please site examples of impairments._____
_____
_____

The individual, due to dysfunction, is at risk for requiring a higher level of care, or is returning from a higher level of care.

Either:

☐ There is clinical evidence that the current intensity of outpatient treatment will not be sufficient to reduce the client's symptoms and functional behavioral impairment resulting from the mental illness and restore him or her to an appropriate functional level, or prevent clinical deterioration, or avert the need to initiate a more intensive level of care due to current risk to the individual or others.

☐ Please explain:
_____
_____

OR

☐ For individuals transitioning from an inpatient, day hospital or residential treatment setting to a community setting there is clinical evidence that PRP services will be necessary to prevent clinical deterioration and support successful transition back to the community, or avert the need to initiate or continue a more intensive level of care. Therapist will make referral to PRP program. The client will be connected with an Outpatient Mental Health Center or mental health provider.

☐ Please Explain: _____
_____

☐ The individual's disorder can be expected to improve through medically necessary rehabilitation or there is clinical evidence that this intensity of rehabilitation is needed to maintain the individual's level of functioning; and

☐ The individual is judged to be in enough behavioral control to be safe in the rehabilitation program and benefit from the rehabilitation provided.

Check all that applies

Rehabilitation Services Requested (Please check all that apply)	
☐ Relapse Prevention	☐ Adaptive Resources
☐ Age-Appropriate Self-Care Skills	☐ Maintaining Living Space
☐ Social Skills	☐ Maintaining Age-Appropriate Boundaries
☐ Independent Living Skills	☐ Maintaining Personal Safety in the Social Environment
☐ Activities to Support Cultural Interests	☐ Time Management
☐ Conflict Resolution	☐ Nutrition Management
☐ Anger Management	☐ Coping Skills
☐ Financial Education	☐ Interpersonal Skills with Authority Figures
☐ Age-Appropriate Self-Care Skills	☐ Recovery challenges
☐ Social Skills	☐ Emotional regulation skills training
☐ Independent Living Skills	☐ Addressing oppositional and defiant behaviors

I am verifying that _____continues to need services from TYIA Rehabilitation Program. Services needed include assessment and continued on-site and/or off-site psychiatric rehabilitation services and crisis management. This service is medically necessary to facilitate the client's wellness and recovery and is based on my assessment of need in the following areas: Please check all that apply.

☐	Inability to establish or maintain employment (pattern of unemployment, underemployment, or sporadic work history)	☐	Inability to perform instrumental activities of daily living (shopping, meal preparation laundry, basic housekeeping, medication management, transportation, and money management
☐	Inability to establish or maintain personal relationships (social withdrawal or isolation, interpersonal conflict or social behavior, other than criminal that is not easily tolerated by the community)	☐	Inability to perform or maintain self-care (hygiene, grooming, nutrition, medical are, personal safety)
☐	Deficiencies in self-direction (inability to independently plan, initiate, organize, and carry out goal directed activities)	☐	Inability to procure financial assistance to support community living

PRP SERVICE REQUIREMENTS

☐ Outpatient mental health services and social supports should be identified and available to the individual outside the program hours and the individual or the individual's parent/guardian should be capable of seeking them when needed when the individual is not attending the rehabilitation program.

☐ There is a documented crisis response plan both inside and outside of program hours coordinated with the primary mental health clinician treating the individual that indicates clear responsibility for the mental health clinician and rehabilitation program.

PLEASE NOTE: In order to initiate service you are required to follow the Three Step Referral Process:

1. Confirm the client is interested in Psychiatric Rehabilitation Day Program Services.
2. Complete the Referral Form.
3. Forward the completed Form. Please use the fax number OR email listed.

Requirements for the Referral Process: Based on COMAR regulations.

1. Clients that have Medical Assistance may start services within a week of receiving the returned referral information.
2. Clients that have only SSDI and Medicare as their primary are considered uninsured for PRP.

PLEASE NOTE: Presently uninsured clients have no guarantee of authorization from Beacon Health and therefore may take longer to be approved for services. A Licensed Mental Health Professional's signature is REQUIRED on the referral form. In order to establish and maintain eligibility for PRP SERVICES, individuals MUST remain under the care of a psychiatrist and/or therapist while in the program.

Name of Therapist:_____
Name of Agency:_____
Address:_____
Phone:_____ **Email:**_____

Mental Health/Counselor Signature:_____**Date:**_____

**********FOR OFFICE USE ONLY**********