



**Robert A. Pascal Youth and Family Services, Inc.**  
**Pascal Crisis Stabilization Center**  
 43 Community Place, Crownsville, MD 21032  
 Phone: 410-571-4500 | Fax: 410-630-7700



Optum Maryland: 800-888-1965 | Provider NPI: 1548618374  
 Attending Physician: Nicholas Scotto, MD / Melissa Ward, CRNP, FNP-C, PMHNP-BC  
 Utilization Review: Melissa Brown

**Psychiatric Rehabilitation Program (PRP) Referral Application**

Name: \_\_\_\_\_ Date of Application: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_ Transition Age Youth? Yes  No

Address: \_\_\_\_\_ County of Residence: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Gender: \_\_\_\_ Race: \_\_\_\_ Ethnicity: \_\_\_\_ Marital Status: \_\_\_\_ Highest Level of Education: \_\_\_\_\_

Employment Status: \_\_\_\_\_ Veteran? Yes  No  If yes, which war: \_\_\_\_\_

Have there been any arrests in past 30 days? Yes  No  If yes, how many? \_\_\_\_\_

Insurance Type: \_\_\_\_\_ Insurance ID #: \_\_\_\_\_ Authorized: Yes  No

If client is an adult, do they have a legal guardian? Yes  No  N/A

If client is a minor, does the parent/guardian have legal custody? Yes  No  N/A

If parent does not have custody, please provide custodial information:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

***\*\*Please note: Services cannot begin unless proof of custody is provided.\*\****

**Reason for Referral (Client Needs and Presenting Problem)**

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DSM 5 Diagnosis: \_\_\_\_\_

Preferred Day/Time of Appointments: \_\_\_\_\_

Other Preferences: \_\_\_\_\_

Suicide Risk: \_\_\_\_ Danger to Self or Others: \_\_\_\_ Urgent/Critical Medical Condition: \_\_\_\_ Immediate Threat(s): \_\_\_\_\_

Past Psychiatric Admission(s): Yes  No  Previous Outpatient Treatment: Yes  No

**Referral Source**

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Organization: \_\_\_\_\_ Phone: \_\_\_\_\_

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



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**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**

*(Please check all that apply)*

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

\_\_\_\_\_  
\_\_\_\_\_

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:
- 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:**

- A) 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**

- B) 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

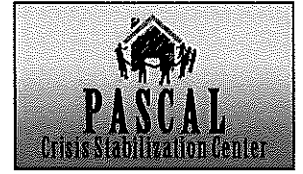


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initiate or continue a more intensive level of care. Therapist will make referral to PRP program.

The client will be connected with an Outpatient Mental Health Center or mental health provider.

*Please explain:*

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- 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.

#### **PRP SERVICE REQUIREMENTS**

- 1. 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.
- 2. 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.



## Pascal Crisis Services, Inc.

Robert A. Pascal Youth & Family Services, Inc. • Pascal Crisis Stabilization Center  
1215 Annapolis Road, Suite 204, Odenton, MD 21113  
(410) 975-0067

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### Consumer's Authorization

I, \_\_\_\_\_, have been offered services at Pascal's PRP Day Program. By signing this, I agree that I have been accepted to attend services at Pascal's PRP Day Program.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Date

43 Community Place  
Crownsville, MD 21032  
(410) 571-4500

1226 Annapolis Road  
Odenton, MD 21113  
(410) 571-4500

1230 Annapolis Road  
Odenton, MD 21113  
(410) 874-1236

741 Annapolis Road  
Gambrills, MD 21054  
(410) 975-0067