



8101 Sandy Spring Road, Suite 250, I, J, K

Laurel, MD 20707

P 240.459.8423

F 419.931.9255

www.cmntycare.com

Adult Psychiatric Rehabilitation Program Referral Form

Date: _____ Referring Agency/Address: _____

Therapist Name : _____ Licensure Level: _____ Phone: _____ Fax: _____

Email Address: _____

Consumer Name: _____ Gender: _____ DOB: _____ Race: _____

Medical Assistance #: _____

Address: _____ Zip: _____ Phone: _____

1. Is the individual currently enrolled in SSI/SSDI? Yes No
2. Is the individual eligible for full funding Developmental Disabilities Administration services? Yes No
3. Is the primary reason for the individual's impairment due to an organic process or syndrome, intellectual disability, a neurodevelopmental disorder, or neurocognitive disorder? Yes No
4. Behavioral Diagnosis (*Please use the current DSM V, ICD-10 diagnoses*) _____ Date: _____
Diagnosis given by: _____ Date: _____
5. Has the individual been found not competent to stand trial or not criminally responsible and is receiving services recommended by a Maryland Department of Health Education? Yes No
6. Is the individual in a Maryland State psychiatric facility with a length of stay of more than 3 months who requires RRP upon discharge? (Select No. if an individual is eligible for Developmental Disability Services?) Yes No
7. Does this person receive remuneration in any form from the PRP? YES NO
8. Duration of current episode of treatment provided to this individual:
Less than one month 3months 6months 12 months More than 12 months
9. Current frequency of treatment provided to this individual:
At least 1x/week At least 1x/2 weeks At least 1x/month At least 1x/3 months At least 1x/6 month
10. Has this individual received PRP services from another PRP service within the past year? Yes No

Please indicate which of the following program(s) the individual is also receiving services from?



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- Mobile Treatment/Assertive Community Treatment(ACT)
- Residential SUD Treatment Service Level 3.3
- Mental Health Intensive Outpatient Program(IOP)
- Inpatient Psychiatric Treatment
- Residential SUD Treatment Service Level 3.5
- Mental Health Partial Hospital Program
- Residential Crisis
- Residential SUD Treatment Service Level 3.7
- SUD Intensive Outpatient Program(IOP)Level 2.1
- SUD Partial Hospitalization Program(IOP)Level 2.2

FUNCTIONAL CRITERIA (Per medical necessity, at least three of the following must be present on a continuing or intermittent basis over the past two years)

Check all that apply and list objective evidence below:

- Marked inability to establish or maintain competitive employment.
- Deficiencies of concentration/persistence/pace leading to failure to complete tasks.
- Marked inability to perform instrumental activities of daily living (eg. Shopping,meal preparation,laundry,medication management).
- Unable to perform self care.
- Marked inability to establish/maintain a personal support system.
- Marked deficiencies in self direction, shown by inability to plan, initiate, organize, and carry out goal directed activities.
- Marked inability to procure financial assistance to support community living.

DURATION OF IMPAIRMENTS:

- Marked functional impairment has been present for less than 2years.
- Marked functional impairment has been limited to less than 3 of the above listed areas.
- Has demonstrated marked impairment functioning primarily due to mental illness in at least three of the areas listed above at least 1-2years.
- Has demonstrated impaired role functioning primarily due to a mental illness for at least 3 years.

ALTERNATIVE SERVICE AND TRANSITION CONSIDERATION:

- o Consideration has been given to using peer supports and other information supports such a family. List attempts and outcomes of any efforts to serve this individual through less formal means such as peer supports or family: _____
- o

Commented [1]: Looks great! My symbol insert was acting wacky.. Thank you for tightening it up..

Commented [JL2R1]:



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- o Functional impairments can be safely addressed at the PRP level of care. List Specific ways in which PRP services are expected to help this individual:

COLLABORATION AGREEMENT

I, _____ (*Therapist Name and Title*), agree to participate in team treatment planning sessions/initial session within two weeks of receipt of the referral and quarterly sessions in person or by phone.

Therapist Signature: _____ Date: _____

For Community Care, LLC Staff Only

Date Referral Received: _____ Received By: _____

