ARCHWAY STATION, INC.

45 QUEEN STREET • CUMBERLAND, MD 21502

REFERRAL for ADULT PSYCHIATRIC REHABILITATION PROGRAM (PRP) SERVICES

(Community-Based Support Services)

Name: _____
First Middle Last

Telephone: (_____) _____-_____ (_____) _____-_____ (_____) _____-_____
Home Cell Other

Address: _____
Street City State Zip

DOB: _____/_____/_____ Age: _____ SS#: _____-_____-_____ Veteran: ☐ Yes ☐ No

Gender Identity:

- ☐ Male
- ☐ Female
- ☐ Choose Not to Disclose
- ☐ Male-to-Female (MTF)/Transgender Female/Trans Woman
- ☐ Female-to-Male (FTM)/Transgender Male/Trans Man
- ☐ Genderqueer, Neither Exclusively Male or Female
- ☐ Additional Gender Category or Other *(please specify)* _____

Medical Assistance #: _____ MCO *(if known)*: _____

Please provide the name and telephone number of a person we can contact in the event that there is difficulty reaching the person being referred for services.

_____ (_____) _____-_____ _____
Name Telephone # Relationship

Do you have a relative that is currently employed by Archway Station, Inc.: ☐ Yes ☐ No

If yes, please provide person's name: _____

Referral Source: *Must be referred by a Licensed Mental Health Professional. A "Licensed Mental Health Professional" eligible to make referrals to a PRP is defined as a Psychiatrist, CRNP-PMH, Licensed Psychologist, LCSW-C, LCPC, APRN-PMH, LCMFT, LCADC, LCPAT, LGMFT, LGADC or LGPAT. LGPC, LGMFT, LGADC, LGPAT and LMSW staff may only make referrals if they are currently in a formal clinical supervision arrangement with a supervisor approved by the Maryland Board of Professional Counselors and Therapists or the Maryland Board of Social Work Examiners, as applicable. (Supervisor's name, title and location must be provided). Referrals from non-mental health professionals who do not have a mental health specialty are not permitted. RN-C, CAC-AD and CSC-AD are not eligible to make referrals. The Licensed Mental Health Professional must be actively enrolled as a Medicaid provider.*

_____ _____ (_____) _____-_____ _____
Name License/Credentials Telephone # Agency

_____ _____ (_____) _____-_____ _____
Supervisor's Name (if applicable) License/Credentials Telephone # Agency

Is the person being referred currently engaged in Outpatient Mental Health Treatment? ☐ Yes ☐ No

If yes, who is their current provider? _____

Clinical Information: *(needed to request authorization for services)*

Required - Most Recent: *(check off attachments included)*

- ☐ Psychiatric/Psychosocial Evaluation
- ☐ Individual Treatment Plan
- ☐ Progress Notes (2 to 3 months of recent notes)

Also, if available: *(check off attachments included)*

- ☐ Discharge Plan (if person is leaving a hospital)
- ☐ Current Physical Exam Results
- ☐ Any other evaluations or information that help describe the person's status/needs.

Diagnosis: *The individual must meet the DSM-5 diagnostic criteria for a Public Behavioral Health System (PBHS) specialty mental health diagnosis in the Priority Population (either Category A or Category B).*

Category A Diagnoses**:

- ☐ **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
- ☐ **F31.2** Bipolar I Disorder, Current or Most Recent Episode Manic, with Psychotic Features
- ☐ **F31.5** Bipolar I Disorder, Most Recent Episode Depressed with Psychotic Features
- ☐ **F31.64** Bipolar I Disorder, Mixed, Severe with Psychotic Features
- ☐ **F33.3** Major Depressive Disorder, Recurrent Episode Severe with Psychotic Features

**** The specific diagnostic criteria may be waived for <u>one</u> of the following two conditions**:

- ☐ An individual committed as not criminally responsible who is conditionally released from a Mental Hygiene Administration facility, according to the provisions of Health General Article, Title 12, Annotated Code of Maryland.
- ☐ An individual in a Mental Hygiene Administration facility with a length of stay of more than 6 months who requires RRP services, but who does not have a target diagnosis. This excludes individuals eligible for Developmental Disabilities services.

OR

Category B Diagnoses:

- ☐ **F31.0** Bipolar I Disorder, Current or Most Recent Episode Hypomanic
- ☐ **F31.13** Bipolar I Disorder, Current or Most Recent Episode Manic, Severe
- ☐ **F31.4** Bipolar I Disorder, Current or Most Recent Episode Depressed, Severe
- ☐ **F31.63** Bipolar I Disorder, Mixed, Severe without Psychotic Features
- ☐ **F31.81** Bipolar II Disorder
- ☐ **F31.9** Bipolar I Disorder, Unspecified
- ☐ **F33.2** Major Depressive Disorder, Recurrent Episode Severe without Psychotic Features
- ☐ **F60.3** Borderline Personality Disorder

For Category A Diagnoses, <u>either</u> of the following may be met. For Category B Diagnoses, the individual being referred must demonstrate <u>three of the listed role functioning impairments for at least two years</u>.**

- ☐ The individual is currently enrolled in SSI or SSDI.
- ☐ The individual demonstrates impaired role functioning <u>for at least two years</u>. To be considered evidence of impaired role functioning, <u>at least three of the following</u> must have been present on a continuing or intermittent basis *(please check all that apply)*:
  - ☐ Marked inability to establish or maintain independent competitive employment
  - ☐ Marked inability to perform instrumental activities of daily living
  - ☐ Marked inability to establish or maintain a personal support system
  - ☐ Marked or frequent deficiencies of concentration, persistence or pace
  - ☐ Marked inability to perform or maintain self-care
  - ☐ Marked deficiencies in self-direction
  - ☐ Marked inability to procure financial assistance to support community living

**Individuals meeting the role functioning impairment criteria who do not yet have two years of impaired functioning may be considered for psychiatric rehabilitation services if they have a new onset Category A Diagnosis and psychiatric rehabilitation services would be considered the most effective means to diminish the risk. Please check here, if applicable ☐

Please list other diagnoses, if applicable:

ICD-10 Code

Mental Health Diagnosis: _____ _____

_____ _____

Medical Diagnosis: _____

_____

Other Conditions that may be a Focus of Clinical Attention: _____

_____

Allergies: ☐ Yes ☐ No

If yes, please describe: _____

Presenting Problem:

_____

_____

_____

Medications Prescribed: ☐ List Attached ☐ Written Below

_____

_____

Ability to take Medications:

☐ Medications Not Prescribed ☐ Independently ☐ With Reminders ☐ With Daily Supervision
☐ Refuses Medications

Substance Use Information:

Substance Use History (*Include details of substance used (including alcohol), dates used, frequency, amount and how used (smoked, IV, etc.)*

_____

_____

_____

Treatment History for Substance Use Disorders *(Include detox, inpatient & outpatient services as well as dates of treatment)*

_____

_____

_____

Psychiatric Hospitalizations:

Most Recent Psychiatric Admission: ____/____/____ Reason:_____

Total # of Psychiatric Admissions: _____ Summary *(include hospital name & dates)*: _____

_____

_____

Legal Information:

Currently on Probation/Parole: ☐ Yes ☐ No If yes, probation end date: ____/____/____

Probation/Parole Officer: _____ (_____) _____-_____
Name Telephone #

Currently on a Conditional Release Order from the Court/Judge: ☐ Yes ☐ No

If yes, conditional release order expiration date: ____/____/____

Has applicant ever been found NCR (Not Criminally Responsible)?: ☐ Yes ☐ No

Community Forensic Aftercare Program: *For applicants that have been adjudicated by the Circuit Court as Not Criminally Responsible:*

CFAP Monitor: _____ (_____) _____-_____
Name Telephone #

Is applicant required to register through the MD Sex Offender Registry: ☐ Yes ☐ No

If yes, specify the level as identified by the MD Sex Offender Registry: ☐ Tier 1 ☐ Tier 2 ☐ Tier 3

Current Charges: _____

_____

Reported Convictions: _____

_____

Risk Assessment Information:

	Never	Past Week-Month	Past Month-Year	Past 2+ Years	Please Provide Specific Details
Suicide Attempts:	☐	☐	☐	☐	
Suicidal Ideations:	☐	☐	☐	☐	
Aggressive Behavior/Violence:	☐	☐	☐	☐	
Fire Setting/Arson:	☐	☐	☐	☐	
Sexual Behavior(s) that are/were: non-consensual, injurious, high-risk, forcible, pedophilia, etc.	☐	☐	☐	☐	
Self-Injurious/Mutilation (not suicidal):	☐	☐	☐	☐	

Signatures:

I understand that this application is being sent in order to determine if I am eligible to obtain rehabilitation services from Archway Station, Inc. This application does not bind me to receive services. I still have the right to change my mind later. I give Archway Station, Inc. permission to communicate with the referral source to discuss and share medical and mental health history and information necessary for my referral.

Signature of Applicant: _____ Date: ____/____/____

I recommend that this person receive rehabilitation services from Archway Station, Inc. (*Must be referred by a Licensed Mental Health Professional. Please see the eligible list of eligible referral sources on page 1 of this referral.)*

Referral Source Signature: _____ Date: ____/____/____

Supervisor Signature *(if applicable)*: _____ Date: ____/____/____

Completed referrals, along with all required attachments, can be submitted via fax or mail.
Please send to the attention of 'Intake Coordinator'.
Fax to (301) 777-8020 or Mail to Archway Station, Inc., 45 Queen St., Cumberland, MD 21502.

FOR INTERNAL USE ONLY

Receipt of Referral:

Agency Received On: _____/_____/_____ Received By: _____ _____/_____/_____ Screened By: _____ _____/_____/_____

MA Verification:

Date Verified: _____/_____/_____ Verified By: _____ ASO Check: _____

Eligibility: _____ Confirmation #: _____
