ARCHWAY STATION, INC.

45 QUEEN STREET • CUMBERLAND, MD 21502

REFERRAL for CHILD, ADOLESCENT & YOUNG ADULT PSYCHIATRIC REHABILITATION PROGRAM (PRP) SERVICES (CAYA)

Youth's Full Name:
First Middle Last

Guardian's Name:
First Middle Last

Relationship to Youth: Is this person the youth's legal guardian?: Select One

Guardian Telephone:
Home Cell Other

Youth Telephone:
Cell

Address:
Street City State Zip

DOB: Age: SS#:

Gender Identity: Select One

If, 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 parent/guardian of the person being referred for services.

Name Telephone # Relationship

Do you have a relative that is currently employed by Archway Station, Inc.: Select One

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? Select One

If yes, who is their current provider?

Diagnosis: ICD-10 Code

Primary Diagnosis:

Secondary Diagnosis:

Medical Diagnosis:

Other Conditions that may be a Focus of Clinical Attention:

Allergies: Select One

If yes, please describe:

Eligibility:

Please verify that the person applying for services meets <u>ALL</u> of the following criteria by placing a check mark in the box and by attaching clinical documentation for support (the list of required clinical documentation is listed below)

- ☐ The youth has a Public Behavioral Health System (PBHS) specialty mental health DSM-5 diagnosis and the youth's impairment(s) and functional behavior can reasonably be expected to be improved or maintained by using these services.
- ☐ The youth's emotional disturbance is the cause of serious dysfunction in multiple life domains (home, school, community).
- ☐ The impairment, as a result of the youth's emotional disturbance, results in:
  - A clear, current threat to the youth's ability to be maintained in his/her customary setting, or
  - An emerging/impending risk to the safety of the youth and others, or
  - Other evidence of significant psychological or social impairments such as inappropriate social behavior causing serious problems with peer relationships and/or family members.
- ☐ The youth, due to the dysfunction, is at-risk for requiring a higher level of care, or is returning from a higher level of care.
- ☐ The youth's condition requires an integrated program of rehabilitation services to return to age appropriate development and to progress accordingly towards independent functioning and independent living skills.
- ☐ The youth does not require a more intensive level of care and is deemed to be able to be safely maintained in the rehabilitation program and to benefit from the rehabilitation provided.
- ☐ There is evidence that the use of pharmacotherapy, if deemed appropriate, has been considered by the primary treating clinician.

And either:

- ☐ There is clinical evidence that the current intensity of outpatient treatment is not sufficient to reduce the youth's symptoms and functional behavioral impairment resulting from the mental illness and restore him/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 youth or others;

Or alternatively:

- ☐ The youth is transitioning from an inpatient, day hospital or residential treatment setting to a Community setting and there is clinical evidence that PRP services will be necessary to prevent clinical deterioration and support a successful transition back to the community or avert the need to initiate or continue a more intensive level of care.

Clinical Documentation: *(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.

Presenting Problem:

Medications Prescribed:

Select One

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: Summarize Below *(include hospital name & dates)*:

Legal Information:

Risk Assessment Information: *If there is a history, please provide specific details*

Suicide Attempts: Select One

Suicidal Ideations: Select One

Aggressive Behavior/Violence: Select One

Sexual Behavior(s) that are/were non-consensual, injurious, high-risk, forcible, pedophilia, etc.: Select One

Self-Injurious/Mutilation (not suicidal): Select One

Signatures:

I understand that this application is being sent in order to determine if my child is eligible to obtain rehabilitation services from Archway Station, Inc. This application does not bind my child 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 my child's medical and mental health history and information necessary for my child's referral. *This referral must be signed by the youth's parent/legal guardian.*

Signature of Parent/Guardian: _____ 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 #: _____
