



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 Male-to-Female (MTF)/Transgender Female/Trans Woman
- Female Female-to-Male (FTM)/Transgender Male/Trans Man
- Choose Not to Disclose 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 NPI #

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

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:**

- | | |
|---|---|
| <input type="checkbox"/> F20.0 Paranoid Schizophrenia | <input type="checkbox"/> F25.9 Schizoaffective Disorder, Unspecified |
| <input type="checkbox"/> F20.1 Disorganized Schizophrenia | <input type="checkbox"/> F28 Other Specified Schizophrenia Spectrum and Other Psychotic Disorder |
| <input type="checkbox"/> F20.2 Catatonic Schizophrenia | <input type="checkbox"/> F29 Unspecified Schizophrenia Spectrum and Other Psychotic Disorder |
| <input type="checkbox"/> F20.3 Undifferentiated Schizophrenia | <input type="checkbox"/> F31.2 Bipolar I Disorder, Current or Most Recent Episode Manic, with Psychotic Features |
| <input type="checkbox"/> F20.5 Residual Schizophrenia | <input type="checkbox"/> F31.5 Bipolar I Disorder, Most Recent Episode Depressed with Psychotic Features |
| <input type="checkbox"/> F20.81 Schizophreniform Disorder | <input type="checkbox"/> F31.64 Bipolar I Disorder, Mixed, Severe with Psychotic Features |
| <input type="checkbox"/> F20.89 Other Schizophrenia | <input type="checkbox"/> F33.3 Major Depressive Disorder, Recurrent Episode Severe with Psychotic Features |
| <input type="checkbox"/> F20.9 Schizophrenia, Unspecified | |
| <input type="checkbox"/> F22 Delusional Disorders | |
| <input type="checkbox"/> F25.0 Schizoaffective Disorder, Bipolar Type | |
| <input type="checkbox"/> F25.1 Schizoaffective Disorder, Depressive Type | |
| <input type="checkbox"/> F25.8 Other Schizoaffective Disorders | |

**** The specific diagnostic criteria may be waived for one 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:

- | | |
|--|--|
| <input type="checkbox"/> F31.0 Bipolar I Disorder, Current or Most Recent Episode Hypomanic | <input type="checkbox"/> F31.81 Bipolar II Disorder |
| <input type="checkbox"/> F31.13 Bipolar I Disorder, Current or Most Recent Episode Manic, Severe | <input type="checkbox"/> F31.9 Bipolar I Disorder, Unspecified |
| <input type="checkbox"/> F31.4 Bipolar I Disorder, Current or Most Recent Episode Depressed, Severe | <input type="checkbox"/> F33.2 Major Depressive Disorder, Recurrent Episode Severe without Psychotic Features |
| <input type="checkbox"/> F31.63 Bipolar I Disorder, Mixed, Severe without Psychotic Features | <input type="checkbox"/> F60.3 Borderline Personality Disorder |

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

- The individual is currently enrolled in SSI or SSDI.
- The individual demonstrates impaired role functioning for at least two years. To be considered evidence of impaired role functioning, at least three of the following 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:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Suicidal Ideations:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Aggressive Behavior/Violence:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fire Setting/Arson:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sexual Behavior(s) that are/were: non-consensual, injurious, high-risk, forcible, pedophilia, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Self-Injurious/Mutilation (not suicidal):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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 #: _____
