The Compass Center: A Program of Archway Station, Inc.
418 Warwick Ave., Cumberland, MD 21502
Phone #: (301)722-2018 / Fax#: (301) 722-2711

Referral for Respite Services (RS)

01/01/2023

ALL INFORMATION ON REFERRAL IS REQUIRED AND MUST BE COMPLETED

Name: ____ Date: ______________________

Address: ____

____

Telephone: _____________________________________ Date of Birth: _________________

Social Security #: _________________________________ Gender: _______ Race: ________

Education: ☐ Below 12th grade ☐ GED ☐ High School Diploma ☐ College

Employment: ____

Emergency Contact: __________________________________ Telephone: _________________

Current Living Arrangement: ____

Marital Status: ____________ Dependent Children: _____________ # in Family: __________

SSI: ___________________ SSDI: __________________ Food Stamps: _________________

Other Income: ____

Veteran: ☐ Yes ☐ No VA Income: ____________ VA Medical Benefits: _____________

Medical Assistance #: _____________________________ Medicare #: ____________________

QMB: ☐ Yes ☐ No

Other Medical Insurance: ____________________________ Policy#: ______________________

Other Payment Source(s): ____

A. Eligibility Screening (all must apply)

- ☐ person is an adult who has serious and persistent mental illness
- ☐ person lives independently; in a family-like setting; or in a residential rehabilitation program (RRP)
- ☐ person is NOT a resident of a therapeutic group home
- ☐ services have been preauthorized

B. Diagnostic Information

Primary Diagnosis: ________________________________ Diagnosis Code: _____________

Secondary Diagnosis: ______________________________ Diagnosis Code: _____________

Other Diagnosis: __________________________________ Diagnosis Code: _____________

Diagnosed by: ______________________________ License/Credentials: _______________

Agency: _______________________________________ Date of Diagnosis: _____________

Presenting Problem(s) (please explain why the person is being referred for respite services):

____

____

____

C. Health Services

Has the person previously been admitted to a psychiatric hospital? ☐ Yes ☐ No

Place of last hospitalization: ____

Other relevant history: ____

Psychiatrist

Name: ____

Address: ____

Telephone #: _________________________________

Therapist

Name: ____

Address: ____

Telephone #: _________________________________

Person has a history of medication non-compliance? ☐ Yes ☐ No

Does the person currently receive psychiatric medication monitoring? ☐ Yes ☐ No

Medication **Dosage** **Frequency**

____

____

____

____

____

Medical Conditions/Limitations/Allergies: ______________________________________

____

____

Date of last physical: __________________ Physician: ______________________________

Address: ___________________________________ Telephone: ______________________

Risk Assessment

☐ Suicidality ☐ Ideation ☐ Plan ☐ Prior Attempts (if known)

☐ Other Risk Behavior: ____

☐ Substance Abuse: ____

D. Rehabilitation Services

Recommended Service Needs: ____

____

____

Respite Care is Needed:

☐ Specific future time ☐ Immediately ☐ Intermittently

Expected Duration of Respite Care: From________________ to _________________

Frequency, level and type of staff contacts needed: _________________________________

____

____

E. Authorization for Services (to be completed by The Compass Center)

ASO Care Manager (full name): ____

HOO45 Respite Services, full day: ☐ Yes ☐ No

Date Range ______________ to _____________ Authorization #: ____________________

Referral Source (name of agency; mental health professional or individual):

____

F. Signatures

Referral source understands that a person discharged for violation of rules or behaviors presenting a risk to self, staff, or others may require emergency care. Secondary level of care or discharges lasting longer than 24hrs will require the submission of a new referral and assessment.

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.

____ Date: _________________

Individual Signature

____ Date: _________________

Signature of Referring Mental Health Professional / Physician

____ ___________________________

Printed Name **Credentials**

____ Date: ________________

Signature of Supervisor (if applicable)

____ ___________________________

Printed Name (if applicable) **Credentials** (if applicable)