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
☐ Genderqueer ☐ Additional Gender Category or Other *(please specify)* _____
☐ Choose Not to Disclose

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

If yes, please provide person's name: _____

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

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

If the person does not have Medicaid, Specified Low-Income Medicare Beneficiary (SLMB), or Qualified Medicare Beneficiary (QMB) eligibility, they must meet one of the four exception criteria to be eligible for state-funded services:

☐ On conditional release from state hospital.
☐ Discharged from inpatient psychiatric hospitalization within the last 6 months. Date of Discharge: ____/____/____
☐ Released from jail within the last 6 months. Date of Release: ____/____/____
☐ Discharged from a RRP within the last 6 months. Date of Discharge: ____/____/____

Referral Source

Type of Provider: ☐ Inpatient ☐ Residential Crisis ☐ Mobile/Assertive Community Treatment
☐ Mental Health RTC ☐ Incarceration ☐ Outpatient Mental Health Provider

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

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

Outpatient Mental Health Provider

☐ Same as Referral Source ☐ _____ _____ _____
Name License/Credentials Agency

Why is ongoing outpatient treatment not sufficient to address concerns? _____

_____

_____

Other Levels of Care

Have any of the following been considered or attempted:

1. Peer supports and/or informal supports such as family ☐ Yes ☐ No
2. Group therapy ☐ Yes ☐ No
3. Targeted Case Management? ☐ Yes ☐ No

If the answer to any of these questions is yes, explain why this has not been successful: _____

_____

If the answer to any of these questions is no, explain why they have not been tried: _____

_____

PRP may not routinely be provided in conjunction with the following: Mobile Treatment/Assertive Community Treatment; Targeted Case Management; IOP (Substance/Mental Health). If the person is receiving one of these services, please provide clinical rationale as to why both services are needed along with a transition plan.

_____

_____

_____

Diagnosis

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

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

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.

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>.**

**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 ☐

- ☐ 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)*. For each one selected you are required to answer the associated questions.

☐ Marked inability to establish or maintain independent competitive employment

1. Describe the symptoms of the Priority Population Diagnosis that affect the person's functioning:

   _____

2. Describe how specifically these symptoms impair the person's functioning:

   _____

3. Provide specific concrete examples of this person's impaired function:

   _____

☐ Marked inability to perform instrumental activities of daily living

1. Describe the symptoms of the Priority Population Diagnosis that affect the person's functioning:

   _____

2. Describe how specifically these symptoms impair the person's functioning:

   _____

3. Provide specific concrete examples of this person's impaired function:

   _____

☐ Marked inability to establish or maintain a personal support system

1. Describe the symptoms of the Priority Population Diagnosis that affect the person's functioning:

   _____

2. Describe how specifically these symptoms impair the person's functioning:

   _____

3. Provide specific concrete examples of this person's impaired function:

   _____

☐ Marked or frequent deficiencies of concentration, persistence or pace

1. Describe the symptoms of the Priority Population Diagnosis that affect the person's functioning:

   _____

2. Describe how specifically these symptoms impair the person's functioning:

   _____

3. Provide specific concrete examples of this person's impaired function:

   _____

☐ Marked inability to perform or maintain self-care

1. Describe the symptoms of the Priority Population Diagnosis that affect the person's functioning:

   _____

2. Describe how specifically these symptoms impair the person's functioning:

   _____

3. Provide specific concrete examples of this person's impaired function:

   _____

☐ Marked deficiencies in self-direction

1. Describe the symptoms of the Priority Population Diagnosis that affect the person's functioning:

   _____

2. Describe how specifically these symptoms impair the person's functioning:

   _____

3. Provide specific concrete examples of this person's impaired function:

   _____

☐ Marked inability to procure financial assistance to support community living

1. Describe the symptoms of the Priority Population Diagnosis that affect the person's functioning:

   _____

2. Describe how specifically these symptoms impair the person's functioning:

   _____

3. Provide specific concrete examples of this person's impaired function:

   _____

Medications

Medications Prescribed: ☐ No Meds Prescribed* ☐ List Attached ☐ Written Below

If Primary Diagnosis is a mood disorder, it is **mandatory** to list all medications used to treat this disorder. Please specify which medications are being used for this purpose.

*If no medications are prescribed, please provide explanation as to why medications are not being used.

_____

_____

Ability to take Medications: ☐ Medications Not Prescribed ☐ Independently ☐ With Reminders ☐ With Daily Supervision ☐ Refuses Medications

Substance Use

Substance Use & Treatment History (*Include details of substance used, including alcohol, dates used, frequency, and amount. Include details of treatment history, including 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: ____/____/____

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

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

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

Please provide any details relating to the person's legal situation that you feel we should be aware of: _____

_____

_____

Risk Assessment

Does the person have a current presentation or history of the following:

Suicide Attempts: ☐ Yes ☐ No

Suicidal Ideations: ☐ Yes ☐ No

Aggressive Behavior/Violence: ☐ Yes ☐ No

Fire Setting/Arson: ☐ Yes ☐ No

Sexual Behaviors: ☐ Yes ☐ No

Self-Injurious Behaviors: ☐ Yes ☐ No

If you answered yes, please provide additional information: _____

_____

_____

Reason for Referral

Please provide details reason you are recommending this person for PRP services:

_____

_____

_____

_____

Clinical Documentation

The following clinical documentation is <u>required</u> and must be submitted along with this completed referral:

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

If there is any other evaluations/information that you feel helps describe the person's need for services, please include that as well.

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. *(Please refer to the Referral Guide for a list of eligible Licensed Mental Health Professionals.)*

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

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

Completed referrals, along with all required documentation, 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 #: _____