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?: ☐ Yes ☐ No

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

Youth Telephone: (_____) _____-_____
Cell

Address: _____
Street City State Zip

DOB: _____/_____/_____ Age: _____ SS#: _____-_____-_____

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)*: _____

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? _____

_____

_____

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Other Levels of Care

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

Primary Diagnosis: _____ ICD-10 Code: _____

Secondary Diagnosis: _____ ICD-10 Code: _____

_____ ICD-10 Code: _____

_____ ICD-10 Code: _____

Medical Diagnosis: _____

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

_____

Functional Impairments

Within the past three months, the person's emotional disturbance has resulted in:

☐ A clear, current threat to their ability to be maintained in their customary setting:
Evidence: _____
_____
_____

☐ An emerging risk to the safety of themselves or others:
Evidence: _____
_____
_____

☐ Significant psychological/social impairments causing serious problems with peer relationships/family members:
Evidence: _____
_____
_____

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.

_____

_____

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

of ER Visits in Past 3 Months: _____ Dates of ER Visits: _____

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

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

_____

Legal Information

_____

_____

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 required 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.

Eligibility

In order to be eligible for services, the person must meet <u>ALL</u> of the following criteria. By submitting this referral, you attest this to be true.

- 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.

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 #: _____