



ARCHWAY STATION, INC.

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 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.

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.**

**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 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*). 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

Fire Setting/Arson: Yes No

Suicidal Ideations: Yes No

Sexual Behaviors: Yes No

Aggressive Behavior/Violence: 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.

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 #: _____