ARCHWAY STATION, INC.

REFERRAL for RESPITE SERVICES (RS)

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 Archway Station, Inc. Respite Staff)

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)