MINDFUL HEALING WORKS

WELLNESS CENTER

CHANGING THE LANDSCAPE
OF MENTAL HEALTH CARE

PRP Adult Initial Authorization Referral Packet

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(TO SAVE: Go onto Google Docs. Then, go to "File" then "Save as Google Docs")

Date of Referral:

Client Name:	DOB:	Age:
CURRENT ADDRESS:		
PRIMARY PHONE #:	ALTERNATIVE PHONE #	
Caregiver/Relationship to client (if applicable)		

Reason for Referral (Check all that apply)

- ☐ Emotional/Mental Illness
- ☐ Employment Instability
- ☐ Financial Instability/Difficulty
- ☐ Medication Mismanagement/Monitoring
- ☐ Behavior/Conduct Problems
- ☐ Legal/Incarceration
- ☐ Suicidal/Homicidal
- ☐ Homelessness/At Risk of Homelessness
- ☐ Substance Abuse
- ☐ Relational Conflicts
- ☐ Physical/Emotional Abuse
- ☐ Social/Interpersonal Challenges
- ☐ Sexual Abuse
- ☐ Other _____

Please Indicate Current DSM V Diagnosis Code

Axis 1:

PRP SERVICES REQUESTED (check all that apply):

Self Care Skills

- ☐ Personal Hygiene
- ☐ Grooming
- ☐ Nutrition
- ☐ Dietary Planning
- ☐ Food Preparation
- ☐ Self Administration of Medications
- ☐ Maintain Personal Living Space
- ☐ Maintain Personal Safety

Social Skills

- ☐ Community Integration Activities
- ☐ Developing Natural Supports
- ☐ Developing Linkages with and supporting the Individual's Participation in Community Activities
- ☐ Interactive skills with Peer and Authority Figures
- ☐ Anger Management and Conflict Resolution Skills

Independent Living Skills

- ☐ Community Awareness
- ☐ Mobility and Transportation Skills
- ☐ Individual Wellness Self-Management and Recovery
- ☐ Money Management
- ☐ Accessing Available Entitlements and Resources
- ☐ Supporting the individual to Obtain and/or Retain Employment
- ☐ Time Management
- ☐ Health Promotion and Training

Symptoms and Behavior/Risk Behaviors

☐ Anxiety/Panic
☐ Hopeless/Helpless
☐ Physical Aggression
☐ Lying/Manipulative
☐ Property Destruction
☐ Self-Injurious Behavior
☐ Depressed
☐ Hyperactive
☐ Stealing
☐ Trauma Related
☐ Impulsive
☐ Manic mood
☐ Homicidal Ideations
☐ Social/Withdrawal
☐ Obsession/Compulsion
☐ Self-care Deficit
☐ Separation Problems
☐ Verbal Aggression
☐ Sexually Inappropriate
☐ Fire Setting
☐ Irritable
☐ Isolative
☐ Running Away
☐ Other _____

Is Client on Medication? (If yes, please list medication and dosage)

☐ Yes ☐ No

History of Problem(s): Include any hospitalization with date(s)

Is Client currently receiving Mental Health Services?

☐ Yes ☐ No

If Yes, Please Specify

Print Treating Therapist Name Phone

Referring Mental Health Professional Signature and Credentials Date

Supervisor Signature/ Credentials (if required) Date

☐ I am authorized to give consent for MHW PRP to collaborate with service providers to receive and verify the information on this form for screening assessment purposes and to determine the appropriateness of services for the above-referred individual.

Service Request Information

Requested Start Date for Authorization:*

Requested Services:** ☐ **On-Site** ☐ **Off-Site** ☐ **Blended**

Diagnostic Information

Please select a Category A **OR a** Category B Diagnosis in the area below

Category A Diagnosis Code:

☐ F20.81 ☐ F20.9 ☐ F22 ☐ F25.0 ☐ F25.1 ☐ F28 ☐ F29 ☐ F31.2 ☐ F31.5 ☐ F33.3

Other Referral Information related to Category A Diagnosis Only

Is the individual currently enrolled in SSI/SSDI?*

☐ Yes ☐ No ☐ Unknown

Is the individual eligible for full funding for Developmental Disabilities Administration services?

☐ Yes ☐ No

Is the primary reason for the individual's impairment due to an organic process or syndrome, intellectual disability, a neurodevelopmental disorder, or neurocognitive disorder?

☐ Yes ☐ No

-OR-

Category B Diagnosis Code:

☐ F31.0 ☐ F31.13 ☐ F31.4 ☐ F31.81 ☐ F31.9 ☐ F33.2 ☐ F60.3

Other Referral Information Related to Category B Diagnosis Only

Has the individual been found not competent to stand trial or not criminally responsible and is receiving services recommended by a Maryland Department of Health Evaluator?**

☐ Yes ☐ No

Is the individual in a Maryland State psychiatric facility with a length of stay of more than 3 months who requires RRP upon discharge? (Select No, if individual is eligible for Developmental Disabilities Services)**

☐ Yes ☐ No

Is the individual currently enrolled in SSI/SSDI?*

☐ Yes ☐ No ☐ Unknown

Is the participant eligible for fully funded Developmental Disabilities Administration services?**

☐ Yes ☐ No

Is the primary reason for the participant's impairment due to an organic process or syndrome, intellectual disability, a neurodevelopmental disorder or neurocognitive disorder?**

☐ Yes ☐ No

Diagnosis given by:

☐ Referring Clinician ☐ Other

If Other: Diagnosing Clinician:

Diagnosing Clinician Agency:* _____

☐ None	☐ APRN-PMH/CRNP-PMH	☐ LCADC	☐ LCMFT	☐ LCPAT
☐ MD/DO	☐ PhD/PsyD	☐ LCPC	☐ LGADC	☐ LGPC
☐ LMSW	☐ LCSW-C			

Clinical Information

Is the individual currently receiving mental health treatment from a licensed mental health professional?

☐ Yes ☐ No

Has the individual been seen at least 4x within 2 months? (mandatory)

☐ Yes ☐ No

If YES, what dates?

Does this licensed mental health professional receive remuneration in any form from the PRP?**

☐ Yes ☐ No

Duration of the current episode of treatment provided to this individual**

☐ Less than one month ☐ 2-3 months ☐ 4-6 months ☐ 7-12 months ☐ More than 12 months

Current frequency of treatment provided to this individual:**

☐ At least 1x/week ☐ At least 1x/2 weeks ☐ At least 1x/month ☐ At least 1x/3 months ☐ At least 1x/6 months

Has this individual received PRP services from at least one other PRP within the past year?**

☐ Yes ☐ No

List any other additional treating providers:

Name:	Credential:	Agency:
Name:	Credential:	Agency:

Please indicate which of the following program(s) the individual is also receiving services from.*

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As of July 1, 2020, PRP may not be provided in conjunction with:

- Mobile Treatment Services (MTS)/Assertive Community Treatment (ACT) -Adult
- Adult Targeted Case Management (TCM)
- Inpatient
- MH-Residential Treatment Center (RTC)
- Residential SUD Treatment Level 3.3
- Residential SUD Treatment Level 3.5
- Residential SUD Treatment Level 3.7
- Residential SUD Treatment Level 3.7WM
- SUD IOP
- MH IOP
- MH PHP
- Residential Crisis

Is the participant currently in treatment or receiving services from one of the services listed above?**

☐ Yes ☐ No

Functional Criteria

Per medical necessity criteria, at least three of the following must have been present on a continuing basis over the past two years. *Evidence written for the criteria must be related only to symptoms of the PRIMARY REFERRED DIAGNOSIS.* Information that is not related to the primary referred diagnosis will not be sufficient for authorization and will likely result in the denial of the client's new authorization.

Does the participant have a marked inability to establish or maintain competitive employment?**

☐ Yes ☐ No

If Yes, explain evidence of marked inability to establish or maintain competitive employment. Describe below.

Does the participant have a marked inability to perform instrumental activities of daily living (eg shopping, meal preparation, laundry, basic housekeeping, medication management, transportation, and money management)?

☐ Yes ☐ No

If Yes, explain evidence of marked inability to perform instrumental activities of daily living (eg shopping, meal preparation, laundry, basic housekeeping, medication management, transportation, and money management)

Does the participant have a marked inability to establish/maintain a personal support system?

☐ Yes ☐ No

If yes, explain evidence of marked inability to establish/maintain a personal support system

Does the participant have marked deficiencies of concentration/ persistence/ pace leading to failure to complete tasks?.

☐ Yes ☐ No

If yes, explain evidence of Deficiencies of concentration/ persistence/ pace leading to failure to complete tasks

Does the participant have a marked inability to perform self-care (hygiene, grooming, nutrition, medical care, safety)?

☐ Yes ☐ No

If Yes, explain evidence of Unable to perform self-care (hygiene, grooming, nutrition, medical care, safety)

Does the participant have marked deficiencies in self-direction, shown by the inability to plan, initiate, organize, and carry out goal-directed activities

☐ Yes ☐ No

If Yes, explain evidence of Marked deficiencies in self-direction, shown by the inability to plan, initiate, organize, and carry out goal-directed activities.

Does the participant have a marked inability to procure financial assistance to support community living?

☐ Yes ☐ No

If Yes, explain evidence of marked inability to procure financial assistance to support community living.

Duration of Impairment(s):

Has the participant demonstrated marked functional impairments for at least 2 years?**

☐ Yes ☐ No

If No, Does the participant have a new onset (within the past 6 months) Category A diagnosis?

☐ Yes ☐ No

Alternative Service Transition Considerations

Consideration has been given to using peer supports and other informal supports such as family.

☐ Yes ☐ No

List attempts and outcomes of any efforts to serve this individual through less formal means such as peer support or family)

Has participant been judged to be in enough behavioral control to be safe in rehab program and benefit from the rehab provided?*

☐ Yes ☐ No

List specific ways in which PRP services are expected to help this individual.

Confirmation and Attestation

☐ I attest that all of the information is accurate and reflected in the individual's record.

Additional Required Information

This section is optional for the client to disclose this information for collection purposes.

Ethnicity & Race

Is the individual of Hispanic, Latina/o, or Spanish Origin?**

☐ Yes ☐ No

Race*

☐ White ☐ American Indian or Alaskan Native ☐ Black or African American ☐ Asian ☐ Native Hawaiian or other Pacific Islander

If the Individual is Multiracial, Select Other Race(s)

☐ White ☐ American Indian or Alaskan Native ☐ Black or African American ☐ Asian ☐ Native Hawaiian or other Pacific Islander

Language

How well does the Individual Speak English? (5 years old or older)**

☐ Very Well ☐ Well ☐ Not Well ☐ Not At All ☐ Not Available

Does the Individual Need Assistance with Communicating in English?**

☐ Yes ☐ No

Does the Individual Speak a Language other than English at Home?**

☐ Yes ☐ No ☐ Not Applicable

Marital Status and Pregnancy

Marital Status*

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow/Widower

Is the Individual pregnant now?*

☐ Yes ☐ No ☐ Not Applicable

Education

Educational Level (Highest level of School Completed)***

☐ No years of schooling ☐ Nursery School, Pre-School (Incl. Head Start) ☐ Kindergarten ☐ Grade 1 ☐ Grade 2 ☐ Grade 3

☐ Grade 4 ☐ Grade 5 ☐ Grade 6 ☐ Grade 7 ☐ Grade 8 ☐ Grade 9

☐ Grade 10 ☐ Grade 11 ☐ Grade 12

☐ Self-Contained Special Education Class
☐ Vocational School
☐ College Undergraduate Freshman (1st year)
☐ College Undergraduate Sophomore (2nd year)
☐ College Undergraduate Junior (3rd year)
☐ College Undergraduate Senior (4th year)
☐ Graduate or Professional School
☐ Unknown

Did the Individual Attend School Any Time in the Past 3 Months?***

☐ Yes ☐ No ☐ Unknown

Current Grade Level**_____

Military/Veteran Status

Is this Individual, a Veteran?*

☐ Yes ☐ No ☐ Not Applicable

If Yes, Which War is the Individual a Veteran of (if More than 1, Note Most Recent)*

☐ Afghanistan ☐ Iraq ☐ None ☐ Other

Specify the Time Frame for Individual's Military Service*

Would the Individual Like to be Contacted by the Office of Maryland's Commitment to Veterans for the Purpose of Veteran Benefits?*

☐ Yes ☐ No ☐ Already in Contact ☐ Unknown

Disability Status

Is the Individual Deaf or hard of Hearing?**

☐ Yes ☐ No

Is the Individual Blind or Having Serious Difficulty Seeing, even when Wearing Glasses?***

☐ Yes ☐ No

Because of a Physical, Mental, or Emotional Condition, is the Individual having Serious Difficulty Concentrating, Remembering, or Making Decisions? (5 years old or older)***

☐ Yes ☐ No

Is the Individual Having Serious Difficulty Walking or Climbing Stairs? (5 years old or older)***

☐ Yes ☐ No

Is the Individual Having Difficulty Dressing or Bathing? (5 years old or older)***

☐ Yes ☐ No

Because of a Physical, Mental, or Emotional Condition, is the Individual Having Serious Difficulties doing Errands Alone such as Visiting a Doctor's Office or Shopping? (15 years old or older)***

☐ Yes ☐ No

Other Information

What is the Individual's Living Arrangement?**

☐ Private Residence ☐ Residential Care ☐ Homeless/Shelter ☐ Institutional Setting
☐ Foster Home ☐ Crisis Residence ☐ Children's Residential Treatment ☐ Jail/Correctional/Facility
☐ Other

Was the Individual Homeless in the Last 6 Months?**

☐ Yes ☐ No

Employment Status**

☐ Employment Full-Time ☐ Retired ☐ Homemaker ☐ Incarcerated/Institutional Resident ☐ Volunteer
☐ Employment Part-Time ☐ Disabled ☐ Student ☐ Unemployed - Seeking Work ☐ Other
☐ Other Unemployed

Tobacco Use in the Past 30 Days**

☐ Yes ☐ No

Does the Individual Smoke Cigarettes?**

☐ Yes ☐ No

Was the Individual Screened for Gambling?***

☐ Yes ☐ No ☐ Yes-Gambling Problem Not Indicated ☐ Yes-Gambling Problem Included in Treatment Here ☐ Yes-Referred to Gambling Treatment elsewhere

Number of Times in Self-help Support Group in the Past 30 Days**

☐ No attendance

☐ Less than once a week-1 to 3 times in the past 30 days

☐ About once a week - 4 to 7 times in the past 30 days

☐ 2 to 3 times per week - 8-15 times in the past 30 days

☐ At least 4 times/wk-16 to 30 times in the past 30 days

☐ Some attendance-number of times & frequency is unknown

☐ Unknown

Number of Arrests in the Past 30 Days**: _____ OR ☐ Missing/Unknown/Not Collected/Invalid

Number of Dependent Children**: _____

Primary Source of Income**

☐ Wages/Salary ☐ Self-Employment ☐ Unemployment Compensation ☐ Other
☐ Public Assistance/TCA ☐ Retirement/Pension ☐ Disability ☐ Unknown

Individual Substance Use Information**

Please confirm individual's substance use history***

☐ Yes ☐ No

If Yes, Expected source of payment*

☐ BHA Grant/Uninsured ☐ Medicaid ☐ Medicare ☐ Non-Managed Private Insurance ☐ Unknown
☐ Out of Pocket Payment ☐ Other Public Funds ☐ Other ☐ Drug Court ☐ Not collected

Psych problem in addition to alcohol or drug*:

☐ Yes ☐ No ☐ Not Applicable

Primary Substance of Use*:		Age at first Use:	

Route of Administration:*:

☐ Not Applicable ☐ Oral ☐ Smoking ☐ Inhalation ☐ Injection ☐ Other

Frequency of Use:*:

☐ No Use Past Month ☐ 1-3x Past Month ☐ 1-2x Past Week ☐ Not Applicable
☐ 3-6x Past Week ☐ Daily ☐ Other

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Intake Client Forms

Basic Information

Full Name: _____

First Name Last Name Suffix

DOB: _____

Assigned Sex at Birth: ◯ Male ◯ Female ◯ Other

Gender Identity: ◯ Man ◯ Woman ◯ Nonbinary/Gender Nonconforming ◯ Other

Primary Phone: ◯ **Home** ◯ **Mobile** ◯ **Work** **Primary Phone Number:** _____

Email: _____ **Social Security Number:** _____

Address Line 1: _____ **Address Line 2:** _____

City: _____ **State/Zip:** _____

Marital Status: _____ **Maiden Last Name:** _____

Driver's License State: _____ **Driver's License #:** _____

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Demographics

Sexual Orientation: _____ **Race:** _____

Hispanic or Latino? ◯ **Yes** ◯ **No** ◯ **Decline to Specify** **Ethnicity:** _____

Primary Language: _____

Emergency Contact

Relationship to Contact: _____

Full Name: _____

Primary Phone: ◯ **Home** ◯ **Work** ◯ **Mobile** **Phone Number:** _____

Email: _____

Address: _____

City: _____ **State/Zip:** _____

Financial Information

Responsible Party:

Who will be financially responsible for you? ◯ **Myself** ◯ **Someone Else**

If you choose "Someone Else", please fill out the following:

Relationship to Contact: _____

Full Name: _____

Primary Phone: ◯ **Home** ◯ **Work** ◯ **Mobile** **Primary Phone #:** _____

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Primary Insurance:

Insurance Company: _____ **Policy Number:** _____

Insurance Plan: _____ **Insurance Phone Number:** _____

Group Number: _____

Insurance Co. Address: _____

State/City/Zip: _____

If you are not the primary holder, please fill out the following:

Relationship to Primary Holder: _____

Full Name: _____

Assigned Sex at Birth: ◯ Male ◯ Female ◯ Other **DOB:** _____

Policy ID Number: _____ **Social Security Number:** _____

Policy Holder Address: _____

City/State/Zip: _____

Additional Information

Please list your preferred pharmacies in order of preference:

Pharmacy Name	Pharmacy Address

How did you hear about us? _____