MINDFUL HEALING WORKS

WELLNESS CENTER

CHANGING THE LANDSCAPE
OF MENTAL HEALTH CARE

PRP Authorization Packet

Child/Adolescent Initial Referral and Authorization Request

Child/Adolescent PRP REFERRAL FORM

In order to be admitted into the program, the client must be referred by a mental health professional, has to be receiving ongoing clinical services at the time of referral or must have an AXIS I diagnosis indicating the severity of psychiatric symptoms that indicate the need for psychiatric rehabilitation services.

Date of Referral:

Requested Start Date (if different from Referral Date):

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

Required: Please Indicate Current DSM V Diagnosis Code

Axis 1 Diagnosis Code:

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

Independent Living Skills

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

Symptoms and Behavior/Risk Behaviors		
☐ Anxiety/Panic	☐ Fire Setting	☐ Running Away
☐ Attachment Problems	☐ Hopeless/Helpless	☐ Social/Withdrawal
	☐ Hyperactive	☐ Oppositional Defiant

☐ Depressed ☐ Homicidal Ideations ☐ Physical Aggression ☐ Manic mood ☐ Property Destruction ☐ Verbal Aggression	☐ Irritable ☐ Lying/Manipulative ☐ Obsession/Compulsion ☐ Self-care Deficit ☐ Suicidal Ideations ☐ Impulsive	☐ Self-Injurious Behavior ☐ Separation Problems ☐ Sexually Inappropriate ☐ Stealing ☐ Trauma Related ☐ Isolative

Is the Client on Medication?

☐ Yes ☐ No (If yes, please list medication and dosage in space below)

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

Print Treating Therapist Name Phone

Referring Mental Health Professional Signature and Credentials Date

Supervisor Signature and Credentials 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.

Psychiatric Rehabilitation Program (PRP) - Child /Adolescent Initial Request

Service Request Information

Requested Start Date for Authorization:*

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

Category A Diagnostic Information

In the space below, please provide the ICD-10 **primary** Diagnosis Code

Per***c COMAR this must be a Public Behavioral Health System (PBHS) specialty mental health diagnosis. For a list of valid diagnoses see:***

https://maryland.optum.com/content/dam/ops-maryland/documents/provider/information/clinicalutilization/Mental-Health-Diagnosis-codes-ICD-10.pdf

ICD-10 Primary Diagnosis Code:

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			

Other Referral Information

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

☐ Yes ☐ No

Have family or peer supports been successful in supporting this youth?

☐ 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

Does the youth meet criteria for a higher level of care than PRP? *

☐ Yes ☐ No

Will the participant's level of cognitive impairment, current mental status or developmental level negatively impact their ability to benefit from PRP? *

☐ Yes ☐ No

Clinical Information

Is youth currently in mental health outpatient or inpatient treatment? *

☐ Yes ☐ No

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

Is the primary clinical treatment provider the person making this referral? *

☐ Yes ☐ No

If no, List Referring Provider Information Name:	Credential:	Agency:
List any additional treating providers. Name:	Credential:	Agency:

**If the primary clinical treatment provider is LGXX or LMXX, please provide supervisor information.		
Supervisor Name*	Credential*	Agency*

The youth has been engaged in active, documented outpatient treatment for: *

☐ Less than a month ☐ Between one and three months ☐ Six months or more

In the past three months, how many ER visits has the youth had for psychiatric care? *

☐ No visits in the last three months ☐ One visit in the last three months ☐ Two or more visits in the last three months

Is the youth transitioning from an inpatient, day hospital, or residential treatment setting to a community setting? *

☐ Yes ☐ No

Does the youth have a Targeted Case Management referral or authorization? *

☐ Yes ☐ No

Has medication been considered for this youth? *

☐ Not Considered ☐ Considered and Ruled Out ☐ Initiated and Withdrawn ☐ Ongoing ☐ Other

Additional Information

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

- Mobile Treatment Services (MTS)/Assertive Community Treatment (ACT)
- Targeted Case Management (TCM)
- Inpatient Psychiatric Services
- Crisis Residential Services
- Psychiatric Residential Treatment Facility (PRTF)/ Residential Treatment Center (RTC)
- Mental Health- Intensive Outpatient Program (IOP)
- Mental Health- Partial Hospitalization Program (PHP)
- Respite
- Therapeutic Behavioral Services (TBS)
- Residential Substance Use Disorder Treatment Level 3.3 or higher
- Substance Use Disorder-Intensive Outpatient Program (IOP)

- Substance Use Disorder- Partial Hospitalization Program (PHP)

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

☐ Yes ☐ No

Functional Criteria

Functional Impairment(s): *Within the past three months, the individual's emotional disturbance has resulted in: **

A clear, current threat to the youth's ability to be maintained in their customary setting? *

- Yes
- No

If no- no additional information is required. **If Yes**, Please write a detailed explanation in the space provided.

*Evidence of a clear, current threat to the youth's ability to be maintained in their customary setting: **

An emerging risk to the safety of the youth or others? *

- Yes
- No

If no- no additional information is required. If Yes, Please write a detailed explanation in the space provided below

Evidence of an emerging risk to the safety of the youth or others:

Significant psychological or social impairments causing serious problems with peer relationships and/or family members? *****

- Yes
- No

If no- no additional information is required. If Yes, Please write a detailed explanation in the space provided below.

Evidence of significant psychological or social impairments causing serious problems with peer relationships and/or family members: *

What evidence exists to show that the current intensity of outpatient treatment for this individual is insufficient to reduce the youth's symptoms and functional behavioral impairments resulting from mental illness? *

How will PRP serve to help this youth get to age-appropriate development, more independent functioning, and independent living skills?

Has a crisis plan been completed with family and/or guardian(s)? *

☐ Yes ☐ No

Has an individual treatment plan/Individual rehabilitation plan been completed? *

☐ Yes ☐ No

Confirmation and Attestation

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

Additional Required Information

This section is optional for the client and guardian 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

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

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

Individual Substance Use Information**

Please confirm individual's substance use history***

- Yes
- No

If Yes, Expected source of payment*

- BHA Grant/Uninsured
- Out of Pocket Payment
- Medicaid
- Other Public Funds
- Medicare
- Other
- Non-Managed Private Insurance
- Drug Court
- Unknown
- 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
- 3-6x Past Week
- 1-3x Past Month
- Daily
- 1-2x Past Week
- Other
- Not Applicable
- Date Last Used:

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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? _____