**Referral for Psychiatric Rehabilitation Program (Adult-PRP)**

**Referral Source Information:** **[ ] Initial** **[ ] Re-Referral**

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| **Name of person making referral:** |  | **Date of Referral:** |  |
| **Name of Agency, if applicable** |  | **Agency Phone#:** |  |
| **Email Address:** |  | **Phone #:** |  |
| **What type of Medicaid provider are you:** | [ ] Individual [ ] Group Practice [ ] Outpatient Mental Health Clinic[ ] Inpatient Mental Health [ ] Residential Treatment Center |
| **What is your NPI number? If a clinic or facility, provide clinic or facility NPI number?** |  |
| **Address:** |  |
| **City/ State/ Zip Code** |  |
| **Mental Health Treatment Being Provided** | [ ] Outpatient Mental Health Services [ ] Inpatient Mental Health Services [ ] Residential Treatment Center |

**Client Information:**

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| **Name:** |  | **Date of Birth:** |  | **Age:** |  |
| **Address:** |  | **City, State, Zip:** |  |
| **Phone #:** |  | **Medicaid #** |  |
| **Sexual Orientation** | [ ] **Heterosexual** [ ] **Gay/Lesbian** [ ] **Bisexual** [ ] **Something Else, Please Describe:**[ ]  **Don’t Know** [ ]  **Decline** | **Language Preference:** |  |
| **Race/Ethnicity:** | [ ] **Amer. Indian/Alaskan Native** [ ] **Asian** [ ] **White** [ ] **Black/African American** [ ] **Native American / Hawaiian or Other Pacific Islander** [ ]  **Hispanic**  [ ]  **Non-Hispanic** |
| **Gender Identification** | **[ ] Male [ ] Female [ ]  Transgender Male/Trans Man/(F to M) [ ] Transgender Female/Trans Woman/(M to F) [ ]  Genderqueer (or gender nonconforming)****[ ]  Additional Gender Category, please specify: [ ]  Decline**  |
| **Access to Transportation for On Site Activities:** |  [ ]  Yes [ ]  No |

This form must be filled out in its entirety in order to allow for medical necessity and authorization for services. Please do not add diagnoses to the form.

**CATEGORY A CATEGORY B (If box is checked, answer questions below)**

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| [ ]  F20.9 Schizophrenia | [ ]  F31.4 Bipolar I, Most Recent Depressed, Severe  |
| [ ]  F20.81 Schizophreniform Disorder  | [ ]  F31.0 Bipolar I, Most Recent Hypomanic  |
| [ ]  F25.1 Schizoaffective Disorder, Depressive  | [ ]  F31.9 Bipolar I, Most Recent Hypomanic, Unspecified |
| [ ]  F29 Unspecified Schizophrenia Spectrum and Other Psychotic Disorder  | [ ]  F31.13 Bipolar I, Most Recent Manic, Severe**[ ]** F33.2 MDD, Recurrent Episode, Severe |
| [ ]  F25.0 Schizoaffective Disorder, Bipolar Type | [ ]  F31.81 Bipolar II Disorder  |
| [ ]  F28 Other Specified Schizophrenia Spectrum and Other Psychotic Disorder | [ ]  F60.3 Borderline Personality Disorder |
| [ ]  F22 Delusional Disorder[ ]  F31.2 Bipolar I, Most Recent Manic, with Psychosis |  |
| [ ]  F31.5 Bipolar I, Most Recent Depressed, w/o Psychosis  |  |
| [ ]  F33.3 MDD, Recurrent, With Psychotic Features |  |
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| **Medication** | **Dose/Route/Frequency** |
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**CLINICAL INFORMATION**1. Is the participant receiving outpatient mental health services? [ ]  Yes [ ]  No,
2. Is the licensed mental health provider enrolled as a provider in the Medicaid program? [ ]  Yes [ ]  No,
3. Has an individual treatment plan/individualized rehabilitation plan been completed? [ ]  Yes [ ]  No,
4. Is individual currently receiving mental health treatment from a licensed mental health professional? [ ]  Yes [ ]  No, ***If yes,***

***If LMSW or LGPC (please provide supervisors name who must be LCSW-C or LCPC-C with your governing Board):***

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 1. Is this person in some way paid by the PRP program or receiving other benefits from the PRP program?

 [ ]  Yes [ ]  No1. Duration of current episode of treatment provided to this individual\*\*

[ ]  Less than one month [ ]  1-3 months [ ]  4-6 months [ ]  7-12 months [ ]  More than 12 months1. 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 months1. Has this individual received PRP services from at least one other PRP within the past year? [ ]  Yes [ ]  No

**Please indicate which of the following program(s) the individual is also receiving services from:\***1. Mobile Treatment/Assertive Community Treatment (ACT): [ ] Not Applicable [ ] Currently [ ] In past 30 days
2. Inpatient Psychiatric Treatment: [ ] Not Applicable [ ] Currently [ ] In past 30 days
3. Residential SUD Treatment Service Level 3.3: [ ] Not Applicable [ ] Currently [ ] In past 30 days
4. Residential SUD Treatment Service Level 3.5: [ ] Not Applicable [ ] Currently [ ] In past 30 days
5. Residential SUD Treatment Service Level 3.7: [ ] Not Applicable [ ] Currently [ ] In past 30 days
6. Mental Health Intensive Outpatient Program (IOP): [ ] Not Applicable [ ] Currently [ ] In past 30 days
7. Mental Health Partial Hospital Program: [ ] Not Applicable [ ] Currently [ ] In past 30 days
8. SUD Intensive Outpatient Program (IOP) Level 2.1: [ ] Not Applicable [ ] Currently [ ] In past 30 days
9. SUD Partial Hospitalization Program (PHP) Level 2.2: [ ] Not Applicable [ ] Currently [ ] In past 30 days
10. Residential Crisis [ ] Not Applicable [ ] Currently [ ] In past 30 days
11. If currently in treatment in one of the services listed above, a written transition plan will be attached to this request:

**FUNCTIONAL CRITERIA*****Per medical necessity criteria, at least three of the following functional impairments must have been present on a continuing or intermittent basis over the past two years.*** **Example:**To understand what is being requested for each of the functional impairments below, a generalized example of a response is provided here:Symptom of Priority Population diagnosis: ParanoiaImpairment impacting Functioning: Paranoia results in being suspicious of others.Example of impaired function: Last week he would not get on the bus because he thought the driver was out to get him. He started yelling at the bus driver.**If your answer is “YES” to the questions below, please answer the functional criteria questions:**[ ] Yes [ ] No - Marked inability to establish or maintain competitive employment.**Describe the symptoms of this Priority Population diagnosis that affect the participant's functioning\***

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**Describe how, specifically, these symptoms impair the participant's functioning\***

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**Provide specific concrete examples of THIS participant's impaired function**

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[ ] Yes [ ] No - Marked inability to perform instrumental activities of daily living (eg: shopping, meal preparation, laundry, basic housekeeping, medication management, transportation, and money management).**Describe the symptoms of this Priority Population diagnosis that affect the participant's functioning\***

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**Describe how, specifically, these symptoms impair the participant's functioning\***

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**Provide specific concrete examples of THIS participant's impaired function**

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[ ] Yes [ ] No - Marked inability to establish/maintain a personal support system.**Describe the symptoms of this Priority Population diagnosis that affect the participant's functioning\***

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**Describe how, specifically, these symptoms impair the participant's functioning\***

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**Provide specific concrete examples of THIS participant's impaired function**

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[ ] Yes [ ] No - Deficiencies of concentration/ persistence/pace leading to failure to complete tasks.**Describe the symptoms of this Priority Population diagnosis that affect the participant's functioning\***

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**Describe how, specifically, these symptoms impair the participant's functioning\***

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**Provide specific concrete examples of THIS participant's impaired function**

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[ ] Yes [ ] No - Unable to perform self-care (hygiene, grooming, nutrition, medical care, safety)**Describe the symptoms of this Priority Population diagnosis that affect the participant's functioning\***

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**Describe how, specifically, these symptoms impair the participant's functioning\***

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**Provide specific concrete examples of THIS participant's impaired function**

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[ ] Yes [ ] No - Marked deficiencies in self-direction, shown by inability to plan, initiate, organize and carry out goal directed activities.**Describe the symptoms of this Priority Population diagnosis that affect the participant's functioning\***

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**Describe how, specifically, these symptoms impair the participant's functioning\***

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**Provide specific concrete examples of THIS participant's impaired function**

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[ ] Yes [ ] No - Marked inability to procure financial assistance to support community living**.** **Describe the symptoms of this Priority Population diagnosis that affect the participant's functioning\***

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**Describe how, specifically, these symptoms impair the participant's functioning\***

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**Provide specific concrete examples of THIS participant's impaired function**

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**Duration of Impairment(s):**Marked functional impairment has been present for less than 2 years. **Yes[ ]  No[ ]** Has demonstrated marked impaired functioning primarily due to a mental illness in at least three of the areas listed above at least 2 years. **Yes[ ]  No[ ]** **Why is ongoing outpatient treatment not sufficient to address concerns? (i.e. How could PRP services benefit the individual?)**

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**Criminal History-** [ ] yes [ ] no **REASON FOR REFERRAL:** *(Indicate the areas you want the PRP to address.)*1. **Self-care skills-** [ ] personal hygiene, [ ] grooming, [ ] nutrition, [ ] dietary planning, [ ] food preparation, [ ] self-administration of medication.
2. **Social Skills-** [ ] community integration activities, [ ] developing natural supports, [ ] developing linkages with and supporting the individual’s participation in community activities.
3. **Independent living skills-** [ ] skills necessary for housing stability, [ ] community awareness, [ ] mobility and transportation skills, [ ] money management, [ ] accessing available entitlements and resources, [ ] supporting the individual to obtain and retain employment, [ ] Health promotion and training, [ ] individual wellness self management and recovery.

**Mental Health Practitioner:**

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| Name: | Date: |
| Signature: | Date: |

***Attach a copy of the current Treatment Plan.***

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| *PRP Staff:* Date Referral, Assertion of Need & Tx Plan Received*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* Screening Scheduled within 5 days?: \_\_\_\_ Yes \_\_\_\_\_ No |

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