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

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

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **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:**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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)**

|  |  |  |
| --- | --- | --- |
| 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 |  | |
| |  |  | | --- | --- | | **Medication** | **Dose/Route/Frequency** | |  |  | |  |  | |  |  | |  |  | |  |  | |  |  |   **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):***   |  | | --- | |  |      1. Is this person in some way paid by the PRP program or receiving other benefits from the PRP program?   Yes  No   1. 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 months   1. 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   1. 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\***   |  | | --- | |  |   **Describe how, specifically, these symptoms impair the participant's functioning\***   |  | | --- | |  |   **Provide specific concrete examples of THIS participant's impaired function**   |  | | --- | |  |   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\***   |  | | --- | |  |   **Describe how, specifically, these symptoms impair the participant's functioning\***   |  | | --- | |  |   **Provide specific concrete examples of THIS participant's impaired function**   |  | | --- | |  |   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\***   |  | | --- | |  |   **Describe how, specifically, these symptoms impair the participant's functioning\***   |  | | --- | |  |   **Provide specific concrete examples of THIS participant's impaired function**   |  | | --- | |  |   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\***   |  | | --- | |  |   **Describe how, specifically, these symptoms impair the participant's functioning\***   |  | | --- | |  |   **Provide specific concrete examples of THIS participant's impaired function**   |  | | --- | |  |   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\***   |  | | --- | |  |   **Describe how, specifically, these symptoms impair the participant's functioning\***   |  | | --- | |  |   **Provide specific concrete examples of THIS participant's impaired function**   |  | | --- | |  |   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\***   |  | | --- | |  |   **Describe how, specifically, these symptoms impair the participant's functioning\***   |  | | --- | |  |   **Provide specific concrete examples of THIS participant's impaired function**   |  | | --- | |  |   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\***   |  | | --- | |  |   **Describe how, specifically, these symptoms impair the participant's functioning\***   |  | | --- | |  |   **Provide specific concrete examples of THIS participant's impaired function**   |  | | --- | |  |   **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?)**   |  | | --- | |  |   **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:**   |  |  | | --- | --- | | Name: | Date: | | Signature: | Date: |   ***Attach a copy of the current Treatment Plan.***   |  | | --- | | *PRP Staff:* Date Referral, Assertion of Need & Tx Plan Received*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* Screening Scheduled within 5 days?: \_\_\_\_ Yes \_\_\_\_\_ No | | |