



MINDFUL HEALING WORKS
WELLNESS CENTER

CHANGING THE LANDSCAPE
OF MENTAL HEALTH CARE

PRP Adult Concurrent Authorization Referral Packet

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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 severity of psychiatric symptoms that indicate the need for psychiatric rehabilitation services

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)		
<input type="checkbox"/> Emotional/Mental Illness	<input type="checkbox"/> Behavior/Conduct Problems	<input type="checkbox"/> Relational Conflicts
<input type="checkbox"/> Employment Instability	<input type="checkbox"/> Legal/Incarceration	<input type="checkbox"/> Physical/Emotional Abuse
<input type="checkbox"/> Financial Instability/Difficulty	<input type="checkbox"/> Suicidal/Homicidal	<input type="checkbox"/> Social/Interpersonal Challenges
<input type="checkbox"/> Medication Mismanagement/Monitoring	<input type="checkbox"/> Homelessness/At Risk of Homelessness	<input type="checkbox"/> Sexual Abuse
	<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Other _____

Please Indicate Current DSM V Diagnosis Code

Axis 1:

PRP SERVICES REQUESTED (check all that apply):

Self Care Skills		
<input type="checkbox"/> Personal Hygiene	<input type="checkbox"/> Dietary Planning	<input type="checkbox"/> Maintain Personal Living Space
<input type="checkbox"/> Grooming	<input type="checkbox"/> Food Preparation	<input type="checkbox"/> Maintain Personal Safety
<input type="checkbox"/> Nutrition	<input type="checkbox"/> Self Administration of Medications	

Social Skills	
<input type="checkbox"/> Community Integration Activities	<input type="checkbox"/> Interactive skills with Peer and Authority Figures
<input type="checkbox"/> Developing Natural Supports	<input type="checkbox"/> Anger Management and Conflict Resolution Skills
<input type="checkbox"/> Developing Linkages with and supporting the Individual's Participation in Community Activities	

Independent Living Skills		
<input type="checkbox"/> Community Awareness	<input type="checkbox"/> Money Management	<input type="checkbox"/> Time Management
<input type="checkbox"/> Mobility and Transportation Skills	<input type="checkbox"/> Accessing Available Entitlements and Resources	<input type="checkbox"/> Health Promotion and Training
Individual Wellness	<input type="checkbox"/> Supporting the individual to Obtain and/or Retain Employment	
Self-Management and Recovery		

Symptoms and Behavior/Risk Behaviors	<input type="checkbox"/> Depressed	<input type="checkbox"/> Homicidal Ideations	<input type="checkbox"/> Fire Setting
	<input type="checkbox"/> Anxiety/Panic	<input type="checkbox"/> Hyperactive	<input type="checkbox"/> Social/Withdrawal
	<input type="checkbox"/> Hopeless/Helpless	<input type="checkbox"/> Stealing	<input type="checkbox"/> Obsession/Compulsion
	<input type="checkbox"/> Physical Aggression	<input type="checkbox"/> Trauma Related	<input type="checkbox"/> Self-care Deficit
	<input type="checkbox"/> Lying/Manipulative	<input type="checkbox"/> Impulsive	<input type="checkbox"/> Separation Problems
	<input type="checkbox"/> Property Destruction	<input type="checkbox"/> Manic mood	<input type="checkbox"/> Verbal Aggression
	<input type="checkbox"/> Self-Injurious Behavior		<input type="checkbox"/> Sexually Inappropriate

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

Category B Diagnosis Code:

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

Diagnosis given by:

Referring Clinician Other

If Other: Diagnosing Clinician:

Diagnosing Clinician Agency:*

<input type="checkbox"/> None	<input type="checkbox"/> APRN-PMH/CRNP-PMH	<input type="checkbox"/> LCADC	<input type="checkbox"/> LCMFT	<input type="checkbox"/> LCPAT
<input type="checkbox"/> MD/DO	<input type="checkbox"/> PhD/PsyD	<input type="checkbox"/> LCPC	<input type="checkbox"/> LGADC	<input type="checkbox"/> LGPC
<input type="checkbox"/> LMSW	<input type="checkbox"/> LCSW-C			

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

- a. Name of Treating Licensed Mental Health Professional* _____
- b. Credentials* _____
- c. Agency* _____
- d. NPI # (optional) _____
- e. Email* _____
- f. Phone* _____
- g. Date of Referral* _____

Is the referral source in some way paid by the PRP program or receiving other benefits from the PRP program?*

Yes No

Current frequency of outpatient clinical treatment:**

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

List any other additional treating providers:

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

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

Yes No

Is the participant/guardian involved in preparation of the plan?*

Yes No

Is the participant/guardian in agreement with the plan?*

Yes No

3. Why is ongoing outpatient treatment not sufficient to address concerns?*

PRP may not routinely 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
- SUD PHP
- MH IOP
- MH PHP
- Residential Crisis

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

Yes No

Occupational

Any individual wanting a job should be referred to Supported Employment. If referred to PRP as well, there needs to be additional justification for why PRP is also required.

Is the participant employed?*

Yes No

Does participant wish to be employed?*

Yes No

Has the participant been referred to supported employment?*

Yes No N/A

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.

1. Does the participant have impairments related to the Priority Population diagnosis in three or more of the functional areas listed below?*
 Yes No

To understand what is being requested for each of the functional impairments below, a generalized example of a response is provided here:

1. Symptom of Priority Population diagnosis: Paranoia
2. Impairment impacting Functioning: Paranoia results in being suspicious of others.
3. 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.

A. 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.

A-1) Describe the symptoms of this Priority Population diagnosis that affect the participant's functioning*

A-2) Describe how, specifically, these symptoms impair the participant's functioning.*

A-3) Provide specific concrete examples of THIS participant's impaired function.*

B. 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)

B-1) Describe the symptoms of this Priority Population diagnosis that affect the participant's functioning*

B-2) Describe how, specifically, these symptoms impair the participant's functioning.*

B-3) Provide specific concrete examples of THIS participant's impaired function.*

C. 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

C-1) Describe the symptoms of this Priority Population diagnosis that affect the participant's functioning*

C-2) Describe how, specifically, these symptoms impair the participant's functioning.*

C-3) Provide specific concrete examples of THIS participant's impaired function.*

D. 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

D-1) Describe the symptoms of this Priority Population diagnosis that affect the participant's functioning*

D-2) Describe how, specifically, these symptoms impair the participant's functioning.*

D-3) Provide specific concrete examples of THIS participant's impaired function.*

E. 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)

E-1) Describe the symptoms of this Priority Population diagnosis that affect the participant's functioning*

E-2) Describe how, specifically, these symptoms impair the participant's functioning.*

E-3) Provide specific concrete examples of THIS participant's impaired function.*

F. 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.

F-1) Describe the symptoms of this Priority Population diagnosis that affect the participant's functioning*

F-2) Describe how, specifically, these symptoms impair the participant's functioning.*

F-3) Provide specific concrete examples of THIS participant's impaired function.*

G. 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.

G-1) Describe the symptoms of this Priority Population diagnosis that affect the participant's functioning*

G-2) Describe how, specifically, these symptoms impair the participant's functioning.*

G-3) Provide specific concrete examples of THIS participant's impaired function.*

Confirmation and Attestation

attest that all of the information is accurate and reflected in the participant's medical 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 College Undergraduate Junior (3rd year)
 Vocational School College Undergraduate Senior (4th year)
 College Undergraduate Freshman (1st year) Graduate or Professional School
 College Undergraduate Sophomore (2nd year) 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
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 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*:

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Yes No Not Applicable

Primary Substance of Use*:		Age at first Use:	
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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