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
❑Depressed
❑Hyperactive
❑Stealing
❑Homicidal Ideations
❑Social/Withdrawal
❑Obsession/Compulsion
❑Fire Setting
❑Irritable
❑Isolative

❑Physical Aggression		❑ Self-care Deficit	❑Running Away
❑Lying/Manipulative	❑ Trauma	❑Separation Problems	❑Other _____
❑Property Destruction	Related	❑Verbal Aggression	
❑Self-Injurious Behavior	❑Impulsive	❑Sexually Inappropriate	
	❑Manic mood		

Is Client on Medication? (If yes, please list medication and dosage/ If no, please explain why the participant is not on medication)

❑ 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

-OR-

Category B Diagnosis Code:

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

Other Referral Information

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

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

1. Individuals referred for PRP must be referred from inpatient, residential crisis, mobile treatment/assertive community treatment, mental health RTC programs, Incarceration or from their treating outpatient mental health provider. Is this participant being referred from:**

☐IP / Crisis Res / Mobile / ACT / RTC / Incarceration ☐Outpatient ☐Neither

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*** _____

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

☐Yes ☐No

If YES, what dates?

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

☐ 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 outpatient clinical 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 participant in ongoing, active treatment with the referring provider?**

☐ Yes ☐ No

List any other additional treating providers:

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

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

Explain why the participant has not been referred to supported employment?*

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

☐Yes ☐No

2.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.*

Status of Less Intensive Levels of Treatment

1: Have peer supports and other informal supports such as family been tried?**

☐ Yes ☐ No

What is the reason this has not been tried?*

2: Has group therapy been tried?**

☐ Yes ☐ No

What is the reason this has not been tried?*

3: Has targeted Case Management been tried?**

☐ Yes ☐ No

What is the reason this has not been tried?*

Confirmation and Attestation

☐ **I 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
☐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