MINDFUL HEALING WORKS

WELLNESS CENTER

CHANGING THE LANDSCAPE
OF MENTAL HEALTH CARE

PRP Authorization Packet

Child/Adolescent Concurrent 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

ICD-10 Primary 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
☐ Depressed	☐ Hyperactive	☐ Oppositional Defiant
	☐ Irritable	☐ Self-Injurious Behavior

☐ Homicidal Ideations ☐ Physical Aggression ☐ Manic mood ☐ Property Destruction ☐ Verbal Aggression	☐ Lying/Manipulative ☐ Obsession/Compulsion ☐ Self-care Deficit ☐ Suicidal Ideations ☐ Impulsive	☐ 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

Has the participant been judged to be in enough behavioral control to be safe in a PRP program and benefit from the rehab provided? *

☐ 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

a. **Name of treating Licensed Mental Health Professional referring individual to PRP*_____**
b. **Credential*_____**
c. **Agency:*_____**
d. **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? * Date of 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*

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

☐ Yes ☐ No

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

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?

Is a documented crisis response plan in progress or completed ?**

☐ Yes ☐ No

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

☐ Yes ☐ No

Confirmation and Attestation

Please note this authorization request is not a guarantee of payment, coverage is still subject to applicable State of Maryland benefits.

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

The information to complete this request was provided by, and is the responsibility of*_____ Title* _____