Initial: 

Re-Referral:

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

**This form must be filled out in its entirety to determine medical necessity and authorization for services.**

**Referral Source Information:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of person / agency making referral:** |  | **Date:** |  |
| **Address:** |  |
| **City/ State/ Zip Code** |  |
| **Mental Health Treatment Being Provided** | o Outpatient Mental Health Services o Inpatient Mental Health Services o Residential Treatment Center |

**Client Information:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Client’s** **name:** |  | **Date of** **Birth:** |  | **Gender Identification:**  |  | **Race:** |  |
| **Address:**  |  | **City, state, zip** **code** |  |
| **Phone** **number:** |  | **Email address:** |  |
| **Medicaid #**  |  | **Is the individual currently** **enrolled in SSI/ SSDI? \*\*** | o Yes o No o Unk now n |
| **Highest level of education** |  | **Access to** **transportation for onsite** **activities** | o Yes o No o Unknown |
| **Language(s) spoken in the home:** |  | **Is Interpretation Needed to Speak with Client?** | o Yes o No o Unknown |
| **Does this** **client have a history of** **substance** **abuse?** | o Yes o No o Unknown | **Does client have a history of** **gambling?** | o Yes o No o Unknown |
| **Does the** **participant** **have** **Medicaid** **(Including** **SLMB or** **QMB)?** | o Yes o No | **Does the** **participant meet one of the four criteria?** | o On Conditional release from state hospital o Discharged from inpatient Psych within last 6 months. o Release from jail within the last six months o Discharged from a PRP within the last six months. o None |

**REASON FOR REFERRAL:** *(Indicate the areas you want the PRP to address.)*

|  |
| --- |
| **Requested Services (Check all that apply)** |

**Synergy Family Services, Inc.**

1425 University Blvd, Suite 265, Hyattsville, Maryland 20783-

 Office: 240-752-2767-Fax: 301-326-4835

prpreferrals@synergyfamilyservices.org



|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Self-Care Skills** Hygiene o Nutrition o P h y s i c a l Health o P e r s o n a l safety | **Social Skills** o Developing supports o Conflict resolution o Boundary awareness o C o m m u n i c a t i o n skills | **Independent Living Skills** o Money management o Maintaining living env’t o Cooking/Shopping o Time management | **Community Resources Coordination** o I d e n t i f y i n g resources o E n t i t l e m e n t Application o H o u s i n g Coordination o Vocational/Job Skill | **Symptom Management** o Psychoeducation o Coping skill development o Mental health education o Emotional Regulation |

**Qualifying Adult Diagnosis**

**(Must be at least one of the following**

|  |
| --- |
| Category A Diagnosis- **Must meet either criteria 1 or 2 under “Additional Service Criteria Requirements” listed below** |
| o F20.81 Schizophreniform Disorder o F20.9 Schizophrenia o F22 Delusional Disorder o F25.0 Schizoaffective Disorder, Bipolar Type o F25.1 Schizoaffective Disorder, Depressive Type o F28 Other Specified Schizophrenia Spectrum and other Psychotic Disorder | o F29 Unspecified Schizophrenia Spectrum and Other Psychotic Disorder o F31.2 Bipolar I Disorder, Current or MRE Manic, / w Psychotic Features o F31.5 Bipolar I disorder, Current or MRE Depressed, /w Psychotic Features o F33.3 MDD, Recurrent Episode, /w Psychotic Features |
| Category B Diagnosis- **Must meet criteria #2 under “Additional Service Criteria Requirements” listed below**. |
| o F31 Bipolar I Disorder, Current or most recent episode Hypomanic. o F31.13 Bipolar I Disorder, Current or Most recent episode Manic, Severe o F31.4 Bipolar I Disorder, Current or most recent episode Depressed, Severe o F31.81 Bipolar II Disorder, Unspecified | o F31.9 Unspecified Bipolar and Related Disorder o F33.2 Major Depressive Disorder, Recurrent Episode, Severe o F60.3 borderline personality disordero F33.2 MDD, Recurrent Episode, w/o Psychotic Features |
| **Participant does not have a category A Diagnosis**  | **Participant does not have a category B Diagnosis**  |  |

**Synergy Family Services, Inc.**

1425 University Blvd, Suite 265, Hyattsville, Maryland 20783-

 Office: 240-752-2767-Fax: 301-326-4835

prpreferrals@synergyfamilyservices.org



|  |
| --- |
|  **Diagnosis\*** **1. Is the participant on medication? \*\*** Yes No **2. Are any of the medications prescribed for MDD or Bipolar? \*\*** Yes No**Medication name: \* Dosage\* Frequency\*** If the participant is not taking medications the provider must enter an explanation as to why no medications are indicated into the text box as shown below **Why are medications not part of the treatment? \***  |
| **Clinical Information**  |
| **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: \*\*\*** o IP/Crisis Res / o Mobile/ ACT/ RTC |o Incarceration| o Outpatient Mental Health | o Neither Is the licensed mental health Provider enrolled as a provider in the Medicaid program? o Yes o No d. NPI#  |
| **Occupational- Is the participant employed? \*\*** o Yes o No o N/A |
| **Has the participant been referred to supported employment? \*\***o Yes o No o N/A |

**Synergy Family Services, Inc.**

1425 University Blvd, Suite 265, Hyattsville, Maryland 20783-

 Office: 240-752-2767-Fax: 301-326-4835

prpreferrals@synergyfamilyservices.org



|  |  |
| --- | --- |
| **Status of Less Intensive Levels of Treatment**  |  |
| **1: Have peer support and other informal support such as family been tried? \*\*** o Yes o No **2 Which of the following less intense services have been tried?** o **Group Therapy** o **Targeted Case Management**  |  |
|  **Individual experiences at least three of the following (please provide explanation)** Has a participant demonstrated marked functional impairments for at least 2 years? o **Yes** o **No** **1a. Does participant have a new onset (within past six months) Category A diagnosis? \*** o  **Yes** o **No**  **2. Does the participant have impairment related to the Priority Population diagnosis in three or more of the functional areas listed below? \*\*** o **Yes** o **No \*\*\* Please note this question has to be answered Yes in order to qualify for PRP services** |
| **Functional Criteria** |
| **Does the participant have marked inability to establish or maintain competitive employment? \*\***  | **Yes**  | **No** |
| ***A-1: If Yes, Describe the symptoms of his Priority Population diagnosis that affect the participant's functioning:***  |
| ***A-2) Describe how, specifically, these symptoms impair the participant’s functioning. \**** ***A-3) Provided specific concrete examples of THIS participant’s impaired function. \****  |
| **Does the participant have 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, Describe the symptoms of his Priority Population diagnosis that affect the participant's functioning:***  ***Describe how, specifically, these symptoms impair the participant’s functioning. \****  ***Provided specific concrete examples of THIS participant’s impaired function. \****  |
| **Does the participant have marked inability to establish/maintain a personal support system?\*\***  | **Yes**  | **No** |
| *i****f Yes, Describe the symptoms of his Priority Population diagnosis that affect the participant's functioning: \*******Describe how, specifically, these symptoms impair the participant’s functioning. \****  ***Provided specific concrete examples of THIS participant’s impaired function. \****  |
| **Does the participant have deficiencies of concentration/ persistence/pace leading to failure to complete tasks?\*\*** | **Yes**  | **No** |

**Synergy Family Services, Inc.**

1425 University Blvd, Suite 265, Hyattsville, Maryland 20783-

 Office: 240-752-2767-Fax: 301-326-4835

prpreferrals@synergyfamilyservices.org



|  |
| --- |
| *i****f Yes, Describe the symptoms of his Priority Population diagnosis that affect the participant's functioning: \*******Describe how, specifically, these symptoms impair the participant’s functioning. \****  ***Provided specific concrete examples of THIS participant’s impaired function. \****  |
| **Is participant unable to perform self-care (hygiene, grooming, nutrition, medical care, safety)?\*\***  | **Yes**  | **No** |
| *i****f Yes, Describe the symptoms of his Priority Population diagnosis that affect the participant's functioning: \*******Describe how, specifically, these symptoms impair the participant’s functioning. \****  ***Provided specific concrete examples of THIS participant’s impaired function. \****  |
| **Does the participant have marked deficiencies in self-direction, shown by inability to plan, initiate, organize and carry out goal directed activities?\*\*** | **Yes**  | **No** |
| *i****f Yes, Describe the symptoms of his Priority Population diagnosis that affect the participant's functioning: \*******Describe how, specifically, these symptoms impair the participant’s functioning. \****  ***Provided specific concrete examples of THIS participant’s impaired function. \****  |
| **Does the participant have marked inability to procure financial assistance to support community living?** | **Yes**  | **No** |
| *i****f Yes, Describe the symptoms of his Priority Population diagnosis that affect the participant's functioning: \*******Describe how, specifically, these symptoms impair the participant’s functioning. \****  ***Provided specific concrete examples of THIS participant’s impaired function. \****  |

**Mental Health Practitioner:**

|  |  |  |  |
| --- | --- | --- | --- |
| Print Name:  |  | Date of referral |  |
| Signature, with credentials |  | Phone number: |  |
| Email address: |  |
| *Clinical supervisor, as applicable:* |  |  |  |

Please include copies of the following:

o *Most recent psychiatric evaluation, as applicable*

o *Most recent biopsychosocial assessment, as applicable*

o *Records of Medication, as applicable*

**Synergy Family Services, Inc.;** prpreferrals@synergyfamilyservices.org

1425 University Blvd, Suite 265, Hyattsville, Maryland 20783 Office: 240-752-2767-Fax: 301-326-4835