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)** |

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|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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 disorder  o 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** |  |

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|  |
| --- |
| **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 |

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|  |  |  |  |
| --- | --- | --- | --- |
| **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** | |

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|  |  |  |
| --- | --- | --- |
| *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*

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