Advantage Psychiatric Services, LLC
Adult Psychiatric Rehabilitation Program (PRP) Referral Form

Fax Referral to 410-780-7178 ☐ New Referral ☐ Re-Referral

DEMOGRAPHIC INFORMATION:	
Client Name:	
Address:	
Phone Number (best and alternate):	
DOB:	SS#:
Medical Assistance # (if uninsured, note if an application is pending):	
Gender:	Race(s):
Marital Status:	Veteran? ☐ Yes ☐ No
Highest Level of Education:	Employment Status:
Primary Language:	Secondary Language:

Preferred Type of Service: ☐ **Onsite (Day Program)** ☐ **Offsite (In Home)**

*If uninsured, Medicare, QMB, or SLMB recipient, additional criteria in order to qualify for services (stepdown from a state hospital, discharge from an acute psychiatric hospitalization in the last 6 months, court ordered in last 6 months or discharged from a RRP within last 6 months.)

BEHAVIORAL DIAGNOSIS

Primary Code/Description: *(Note that eligibility for PRP services is restricted to the following below diagnoses (updated to reflect DSM-5))*

☐	**Category A/ F20.0**	**Paranoid Schizophrenia**
☐	**Category A/ F20.1**	**Disorganized Schizophrenia**
☐	**Category A/ F20.2**	**Catatonic Schizophrenia**
☐	**Category A/ F20.3**	**Undifferentiated Schizophrenia**
☐	**Category A/ F20.5**	**Residual Schizophrenia**
☐	**Category A/ F20.81**	**Schizophreniform Disorder**
☐	**Category A/ F20.89**	**Other Schizophrenia**
☐	**Category A/ F20.9**	**Schizophrenia, unspecified**
☐	**Category A/ F25.0**	**Schizoaffective Disorder, Bipolar Type**
☐	**Category A/ F25.1**	**Schizoaffective Disorder, Depressive Type**
☐	**Category A/ F25.8**	**Other Schizoaffective Disorder**
☐	**Category A/ F25.9**	**Schizoaffective Disorder, unspecified**
☐	**Category A/ F22.0**	**Delusional Disorders**
☐	**Category A/ F28.0**	**Other Psychotic Disorder**
☐	**Category A/ F29.0**	**Unspecified Psychosis**
☐	**Category A/ F31.2**	**Bipolar I Disorder, current episode manic, severe with psychotic features**
☐	**Category A/ F31.5**	**Bipolar I Disorder, current episode depressed, severe with psychotic features**
☐	**Category A/ F31.64**	**Bipolar I Disorder, current episode mixed, severe with psychotic features**
☐	**Category A/ F33.3**	**Major Depressive Disorder, recurrent, severe with psychotic features**
☐	**Category B/ F31.0**	**Bipolar I Disorder, current episode hypomanic**
☐	**Category B/ F31.13**	**Bipolar I Disorder, current episode manic, severe without psychotic features**
☐	**Category B/ F31.4**	**Bipolar I Disorder, current episode depressed, severe without psychotic features**
☐	**Category B/ F31.63**	**Bipolar I Disorder, current episode mixed, severe without psychotic features**
☐	**Category B/ F31.81**	**Bipolar II Disorder**
☐	**Category B/ F31.9**	**Bipolar Disorder, unspecified**
☐	**Category B/ F33.2**	**Major Depressive Disorder, recurrent, severe without psychotic features**
☐	**Category B/ F60.3**	**Borderline Personality Disorder**

ADDITIONAL BEHAVIORAL DIAGNOSES DESCRIPTIONS: (Please use code#)	
Diagnosis Code #2:	Diagnosis Code #3:

MEDICAL DIAGNOSES DESCRIPTIONS: (Please use code#)	
Diagnosis Code #1:	Diagnosis Code #2:

Is the primary reason for the participant's impairment due to an organic process or syndrome, intellectual disability, a neurodevelopmental disorder or neurocognitive disorder (e.g. dementia, autism, stroke, brain injury)? If the answer is YES, participant is <u>NOT eligible</u> for services.

MEDICATIONS ONLY RELATED TO BEHAVIORAL HEALTH DX (If Known):		
Medication Name (required)	**Dosage (required)**	**Frequency (required)**
Please attach a Medication Log and an ITP.		

CLINICAL INFORMATION:	
Diagnosed By: (clinician's name, credentials, agency required)	**Legal Involvement in last 6 months**: ☐ Yes ☐ No
How long has participant been seeking mental health services? Please include any time prior to you and/or your agency if applicable. ☐ less than 1 month ☐ 2-3 months ☐ 4-6 months ☐ 7-12 months ☐ more than 12 months	**How often are they seen**: ☐ 1x/weekly ☐ 2x/weekly ☐ 1x/2 weeks ☐ Other ☐ Also being seen in psychiatry/NP/med management monthly **(If participant is only seen 1x monthly in therapy and not at all in psychiatry, med management or by an NP, they will not qualify)**
Psychiatric hospitalization stay in the last 6 months? ☐ Yes ☐ No	**Please include dates of recent hospitalization stay(s):**

SOCIAL ELEMENTS IMPACTING DIAGNOSIS:

☐ None ☐ Educational ☐ Financial ☐ Problems with Access to Healthcare Services
☐ Problems Related to Interactions with Legal System/Crime ☐ Primary Support Group
☐ Housing Problems (Not Homelessness) ☐ Occupational Problems
☐ Homeless ☐ Problems Related to the Social Environment ☐ Unknown
☐ Other Psychosocial and Environmental Problems- Please specify:

FUNCTIONAL CRITERIA

FUNCTIONAL IMPAIRMENTS- Individual <u>MUST</u> experience at least 3 functional impairments below. <u>No previous referrals are to be used again please or Carelon will automatically decline the new authorization request.</u>

1. ☐ Inability to establish or maintain competitive employment.

2. ☐ Inability to perform instrumental activities of daily living like shopping, meal prep, med management, laundry, basic housekeeping, transportation and money management.

3. ☐ Inability to establish and/or maintain a personal support system.

4. ☐ **Deficiencies of concentration, persistence or pace leading to failure to complete tasks.**

5. ☐ **Inability to perform or maintain self-care (hygiene, grooming, nutrition, medical care, safety).**

6. ☐ **Deficiencies in self-direction, shown by inability to plan, initiate, organize and carry out goal-directed activities.**

7. ☐ **Inability to obtain financial assistance to support community living.**

History of SI and HI.

COMMENTS (Additional Needs/Areas of Concern):

Clinician Information: (Clinician listed MUST be enrolled in Medicaid)

Print Referring Clinician's Name and Credentials: _____

Email Address: _____ **Phone:** _____

Referring Clinician's Signature and Credentials: _____

(Please list your name as it appears with the licensing board)

Enrolled NPI: _____ **Date of Referral:** _____

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