Referral for Psychiatric Rehabilitation Program (Adult-PRP)

Referral Source Information: ☐ **Initial** ☐ **Re-Referral**

Name of person making referral:		**Date of Referral:**	
Name of Agency, if applicable		**Agency Phone#:**	
Email Address:		**Phone #:**	
Referring Provider NPI			
What type of Medicaid provider are you:	☐ Individual ☐ Group Practice ☐ Outpatient Mental Health Clinic ☐ Inpatient Mental Health ☐ Residential Treatment Center		
What is your NPI number? If a clinic or facility, provide clinic or facility NPI number?			
Address:			
City/ State/ Zip Code			
Mental Health Treatment Being Provided	☐ Outpatient Mental Health Services ☐ Inpatient Mental Health Services ☐ Residential Treatment Center		

Client Information:

Name:		**Date of Birth:**		**Age:**	
Address:		**City, State, Zip:**			
Phone #:		**Medicaid #**			
Sexual Orientation	☐ **Heterosexual** ☐ **Gay/Lesbian** ☐ **Bisexual** ☐ **Something Else, Please Describe:** ☐ **Don't Know** ☐ **Decline**	**Language Preference:**			
Race/Ethnicity:	☐ **Amer. Indian/Alaskan Native** ☐ **Asian** ☐ **White** ☐ **Black/African American** ☐ **Native American / Hawaiian or Other Pacific Islander** ☐ **Hispanic** ☐ **Non-Hispanic**				
Gender Identification	☐ **Male** ☐ **Female** ☐ **Transgender Male/Trans Man/(F to M)** ☐ **Transgender Female/Trans Woman/(M to F)** ☐ **Genderqueer (or gender nonconforming)** ☐ **Additional Gender Category, please specify:** ☐ **Decline**				
Access to Transportation for On Site Activities:	☐ Yes ☐ No				

This form must be filled out in its entirety in order to allow for medical necessity and authorization for services. Please do not add diagnoses to the form.

CATEGORY A

- ☐ F20.9 Schizophrenia
- ☐ F20.81 Schizophreniform Disorder
- ☐ F25.1 Schizoaffective Disorder, Depressive
- ☐ F29 Unspecified Schizophrenia Spectrum and Other Psychotic Disorder
- ☐ F25.0 Schizoaffective Disorder, Bipolar Type
- ☐ F28 Other Specified Schizophrenia Spectrum and Other Psychotic Disorder
- ☐ F22 Delusional Disorder
- ☐ F31.2 Bipolar I, Most Recent Manic, with Psychosis
- ☐ F31.5 Bipolar I, Most Recent Depressed, w/o Psychosis
- ☐ F33.3 MDD, Recurrent, With Psychotic Features

CATEGORY B (If box is checked, answer questions below)

- ☐ F31.4 Bipolar I, Most Recent Depressed, Severe
- ☐ F31.0 Bipolar I, Most Recent Hypomanic
- ☐ F31.9 Bipolar I, Most Recent Hypomanic, Unspecified
- ☐ F31.13 Bipolar I, Most Recent Manic, Severe
- ☐ F33.2 MDD, Recurrent Episode, Severe
- ☐ F31.81 Bipolar II Disorder
- ☐ F60.3 Borderline Personality Disorder

Medication	Dose/Route/Frequency

CLINICAL INFORMATION

1. Is the participant receiving outpatient mental health services? ☐ Yes ☐ No,
2. Is the licensed mental health provider enrolled as a provider in the Medicaid program? ☐ Yes ☐ No,
3. Has an individual treatment plan/individualized rehabilitation plan been completed? ☐ Yes ☐ No,
4. Is individual currently receiving mental health treatment from a licensed mental health professional? ☐ Yes ☐ No, ***If yes, If LMSW or LGPC (please provide supervisors name who must be LCSW-C or LCPC-C with your governing Board):***

6. Is this person in some way paid by the PRP program or receiving other benefits from the PRP program?
   ☐ Yes ☐ No
7. Duration of current episode of treatment provided to this individual**
   ☐ Less than one month ☐ 1-3 months ☐ 4-6 months ☐ 7-12 months ☐ More than 12 months
8. 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
9. Has this individual received PRP services from at least one other PRP within the past year? ☐ Yes ☐ No

Please indicate which of the following program(s) the individual is also receiving services from:*

1. Mobile Treatment/Assertive Community Treatment (ACT): ☐Not Applicable ☐Currently ☐In past 30 days
2. Inpatient Psychiatric Treatment: ☐Not Applicable ☐Currently ☐In past 30 days
3. Residential SUD Treatment Service Level 3.3: ☐Not Applicable ☐Currently ☐In past 30 days
4. Residential SUD Treatment Service Level 3.5: ☐Not Applicable ☐Currently ☐In past 30 days
5. Residential SUD Treatment Service Level 3.7: ☐Not Applicable ☐Currently ☐In past 30 days
6. Mental Health Intensive Outpatient Program (IOP): ☐Not Applicable ☐Currently ☐In past 30 days
7. Mental Health Partial Hospital Program: ☐Not Applicable ☐Currently ☐In past 30 days
8. SUD Intensive Outpatient Program (IOP) Level 2.1: ☐Not Applicable ☐Currently ☐In past 30 days
9. SUD Partial Hospitalization Program (PHP) Level 2.2: ☐Not Applicable ☐Currently ☐In past 30 days
10. Residential Crisis ☐Not Applicable ☐Currently ☐In past 30 days
11. If currently in treatment in one of the services listed above, a written transition plan will be attached to this request:

FUNCTIONAL CRITERIA

Per medical necessity criteria, at least three of the following functional impairments must have been present on a continuing or intermittent basis over the past two years.

Example:

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.**

If your answer is "YES" to the questions below, please answer the functional criteria questions:

☐Yes ☐No - Marked inability to establish or maintain competitive employment.

Describe the symptoms of this Priority Population diagnosis that affect the participant's functioning*

Describe how, specifically, these symptoms impair the participant's functioning*

Provide specific concrete examples of THIS participant's impaired function

☐Yes ☐No - Marked inability to perform instrumental activities of daily living (eg: shopping, meal preparation, laundry, basic housekeeping, medication management, transportation, and money management).

Describe the symptoms of this Priority Population diagnosis that affect the participant's functioning*

Describe how, specifically, these symptoms impair the participant's functioning*

Provide specific concrete examples of THIS participant's impaired function

☐Yes ☐No - Marked inability to establish/maintain a personal support system. (eg: shopping, meal preparation, laundry, basic housekeeping, medication management, transportation, and money management).

Describe the symptoms of this Priority Population diagnosis that affect the participant's functioning*

Describe how, specifically, these symptoms impair the participant's functioning*

Provide specific concrete examples of THIS participant's impaired function

☐Yes ☐No - Deficiencies of concentration/ persistence/pace leading to failure to complete tasks.

Describe the symptoms of this Priority Population diagnosis that affect the participant's functioning*

Describe how, specifically, these symptoms impair the participant's functioning*

Provide specific concrete examples of THIS participant's impaired function

☐Yes ☐No - Unable to perform self-care (hygiene, grooming, nutrition, medical care, safety)

Describe the symptoms of this Priority Population diagnosis that affect the participant's functioning*

Describe how, specifically, these symptoms impair the participant's functioning*

Provide specific concrete examples of THIS participant's impaired function

☐Yes ☐No - Marked deficiencies in self-direction, shown by inability to plan, initiate, organize and carry out goal directed activities.

Describe the symptoms of this Priority Population diagnosis that affect the participant's functioning*

Describe how, specifically, these symptoms impair the participant's functioning*

Provide specific concrete examples of THIS participant's impaired function

☐Yes ☐No - Marked inability to procure financial assistance to support community living.

Describe the symptoms of this Priority Population diagnosis that affect the participant's functioning*

Describe how, specifically, these symptoms impair the participant's functioning*

Provide specific concrete examples of THIS participant's impaired function

Duration of Impairment(s):

Marked functional impairment has been present for less than 2 years. **Yes**☐ **No**☐
Has demonstrated marked impaired functioning primarily due to a mental illness in at least three of the areas listed above at least 2 years. **Yes**☐ **No**☐

Why is ongoing outpatient treatment not sufficient to address concerns? (i.e. How could PRP services benefit the individual?)

Criminal History- ☐yes ☐no

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

1) **Self-care skills-** ☐personal hygiene, ☐grooming, ☐nutrition, ☐dietary planning, ☐food preparation, ☐self-administration of medication.
2) **Social Skills-** ☐community integration activities, ☐developing natural supports, ☐developing linkages with and supporting the individual's participation in community activities.
3) **Independent living skills-** ☐skills necessary for housing stability, ☐community awareness, ☐mobility and transportation skills, ☐money management, ☐accessing available entitlements and resources, ☐supporting the individual to obtain and retain employment, ☐Health promotion and training, ☐individual wellness self management and recovery.

Mental Health Practitioner:

Name:	Date:
Signature:	Date:

Attach a copy of the current Treatment Plan.

PRP Staff: Date Referral, Assertion of Need & Tx Plan Received: _____ Screening Scheduled within 5 days?: ____ Yes _____ No