Healthy Transitions (HT) provides supportive services to Transition Age Youths – young adults ages 16- 25. The goal of Healthy Transitions is to provide services that will support an individual to achieve milestones and make progress on goals for independent living, completing high school and/or starting postsecondary education, getting, and keeping competitive paid employment, and learning to navigate supports with and from family members and professionals. Healthy Transitions (HT) provides staff support around areas of personal needs such as independent living skills, symptom management, stress management, relapse prevention planning, employment, education and/or vocational services, crisis prevention and other services that will help with the individual's recovery.

**Please see the enclosed Healthy Transitions (HT) application:**

* The mental health professional and/or mental health provider who works closely with the applicant may assist the applicant in completing the attached forms. A licensed mental health professional must complete the attached Referral Form.
* Applicant must sign the Consent form for the Release of Information for HT Services.
* Medical Necessity Criteria must indicate why the applicant is struggling to function independently in the community without mental health services.
* All applications should be faxed to BH Admin at 410-381-5317, emailed to BHAdmin@humanim.org, or mailed to the address below. Please put HT Referral in the Subject Line.

Applicant Information: Please complete this section. If there is a section that is unknown to the referral source, indicate with “N/A”.

|  |  |  |
| --- | --- | --- |
| \*Applicant’s Name: Last:  | First:  | M.I: |
| \*Address: (Current or Last Known) | \*Phone Numbers:Mobile:Home:Email:  |
| \*Date of Birth (MM/DD/YYY):Age: | \*Social Security #: |
| Gender:\_\_ Male \_\_ Female\_\_ TransgenderSexual Orientation (Optional): | Race: | Emergency Contact (Name/Number): |
| Marital Status: |
| Primary Language:Secondary Language (Optional): | \_\_ U.S. Citizen\_\_ Legal Resident |

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| --- |
| Highest Level of Education Completed: |
| Employment Status: |
| What stands in the way of you completing the things you need to/would like to do? |
| Why are you applying for services?  |
| What are your goals? |
| What daily activities and skills do you want assistance with? Are there any activities or behaviors that youstruggle when you are not feeling well? Please check all that apply: |
| ☐Personal hygiene and grooming ☐Food preparation ☐Making healthy food choices ☐Meeting new people ☐Using supports ☐Doing well in school ☐Staying safe  | ☐Exercising ☐Keeping room/home clean ☐Managing money, budgeting ☐Getting along with friends ☐Getting/using resources☐Using transportation | ☐Following housing rules ☐Taking medications consistently ☐Accessing resources ☐Getting along with family ☐Getting and keeping jobs ☐Making good decisions☐ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Somatic/Physical Health Diagnoses or Concerns: |
| Previous History of Drug and Alcohol Use (Type, when used, how much and how used):Current Drug and/or Alcohol Use: (Type, when used, how much and how used):Any Treatment for Substance Use (Past or Present): |
| \*Hospitalization History (When, Where and the Reason): |

|  |
| --- |
| Current Providers and Supports: (or most recent if not currently in treatment) |
| Name/Title: | Agency/Program | Contact Information |
| Psychiatrist/Prescriber: |  | Telephone:Fax:Email: |
| Therapist: |  | Telephone:Fax:Email: |
| Primary Care: |  | Telephone:Fax:Email: |
| Referral Source: |  | Telephone:Fax:Email: |
| Other Providers/Supports: |  | Telephone:Fax:Email: |

|  |
| --- |
| Current Income, Entitlements, and Insurance: |
| Type of Income | Amount (Monthly): | Status: |
| Supplemental Security Income(SSI)Or Social Security Disability Insurance SSDI | $ | ☐Receiving ☐Applied - Pending ☐Applied – Denied |
| \*Medicaid (MA)Medicare (MC) | ## | ☐Receiving ☐Applied - Pending ☐Applied - Denied |
| Employment Income | $ | ☐Receiving ☐Applied - Pending ☐Applied - Denied |
| Other Income (Food Stamps, TCA, etc): | $ | ☐Receiving ☐Applied - Pending ☐Applied - Denied |

* **Applicants**: Please give this and the following pages to your mental health professional(s) (therapist or prescriber) All applicants must get this form completed to be eligible for services. This form must include a Priority Population Diagnosis. If you are not currently receiving clinical services from a mental health professional but would like to be, get your most recent healthcare providers to complete this form, HT service providers will be able to assist you with getting new services or service provider after you are enrolled.
* **Clinicians**: The information in this form will be used to determine whether the applicant meets the Medical Necessity Criteria. Please complete to the best of your ability and elaborate wherever possible. Clearly demonstrated Medical Necessity is required for your patient/consumer to have their services funded.

|  |
| --- |
|  |
| **Individual’s Name:**  |  |  |  |
|  | **(Last)** | **(First)** | **(Middle)** |
| **Individual’s Address:** |
| **Home #:** |  | **Mobile #:** |  | **Email:** |
| **Sex:** **[ ]** Female**[ ]** Male **Race: [ ]  Caucasian [ ]  African American [ ]  Hispanic [ ]  Asian [ ]  Other** |
| **DOB:**       | **Age:**       | **Medical Assistance #:**      | **MCO:**       |
| **In order to qualify for services the individual must meet one of the following DSM 5 diagnoses** |
| **Primary Behavioral Health Diagnosis (check all that apply):** |
| **√** | ICD-9 | ICD-10 | DSM 5 Diagnosis | **√** | ICD-9 | ICD-10 | DSM 5 Diagnosis |
| [ ]  | 295.90 | F20.9 | Schizophrenia | [ ]  | 296.43 | F31.13 | Bipolar I Disorder, Current or Most Recent Episode, Manic, Severe without Psychotic Features |
| [ ]  | 295.40 | F20.81 | Schizophreniform Disorder | [ ]  | 296.44 | F31.2 | Bipolar I Disorder, Current or Most Recent Episode, Manic, Severe with Psychotic Features |
| [ ]  | 295.70 | F25.0 | Schizoaffective Disorder, Bipolar Type | [ ]  | 296.53 | F31.4 | Bipolar I Disorder, Current or Most Recent Episode, Depressed, Severe without Psychotic Features |
| [ ]  | 298.8 | F28 | Schizoaffective Disorder, Depressive Type | [ ]  | 296.54 | F31.5 | Bipolar I Disorder, Current or Most Recent Episode, Depressed, Severe with Psychotic Features |
| [ ]  | 298.9 | F29 | Other Specified Schizophrenia Spectrum and Other Psychotic Disorder | [ ]  | 296.40 | F31.0 | Bipolar I Disorder, Current or Most Recent Episode, Hypomanic |
| [ ]  | 297.1 | F22 | Unspecified Schizophrenia Spectrum and Other Psychotic Disorder | [ ]  | 296.40 | F31.9 | Bipolar I Disorder, Current or Most Recent Episode, Hypomanic, Unspecified |
| [ ]  | 296.33 | F33.2 | Major Depressive Disorder, Recurrent Episode, Severe without Psychotic Features | [ ]  | 296.7 | F31.9 | Bipolar I Disorder, Current or Most Recent Episode, Unspecified |
| [ ]  | 296.34 | F33.3 | Major Depressive Disorder, Recurrent Episode, Severe with Psychotic Features | [ ]  | 296.89 | F31.81 | Bipolar II Disorder |
| [ ]  | 301.22 | F21 | Schizotypal Personality Disorder | [ ]  | 301.83 | F60.3 | Borderline Personality Disorder |
| **√** | **The diagnostic criteria may be waived for either one of the following two conditions:** |
| [ ]  | An individual committed as not criminally responsible who is conditionally released from a Mental Hygiene facility, according to the provisions of Health General Article, Title 12, Annotated Code of Maryland |
| [ ]  | An individual in a Mental Hygiene facility (including Residential Treatment Center) with a length of stay of more than 6 months who requires RRP services. ***This excludes individuals eligible for Developmental Disabilities services.*** |
| **Social Elements Impacting Diagnosis (Check all that apply):** |
| [ ]  None | [ ]  Access to Health Care  | [ ]  Housing Problems | [ ]  Social Environment |
| [ ]  Educational | [ ]  Legal System/Crime | [ ]  Occupational | [ ]  Homelessness |
| [ ]  Financial  | [ ]  Primary Support  | [ ]  Other Psychosocial/Enviro. | [ ]  Unknown  |
|  |
| **Individual experiences at least 3 of the following:** |
| [ ]  Inability to maintain independent employment | [ ]  Severe inability to establish or maintain social supports |
| [ ]  Social behavior that results in interventions by the mental health system | [ ]  Need or assistance with basic living skills |
| [ ]  Inability, due to cognitive disorganization, to procure financial assistance to support living in the community |
|  |
| **If the individual has a co-occurring Substance Use Disorder (cannot be primary diagnosis)** |
| **√** | ICD-9 | ICD-10 | DSM 5 Diagnosis | **√** | ICD-9 | ICD-10 | DSM 5 Diagnosis |
| [ ]  | 305.00 | F10.10 | Alcohol Use Disorder – Mild | [ ]  | 304.20 | F14.20 | Stimulant-Related Disorder – Cocaine – Severe |
| [ ]  | 303.90 | F10.20 | Alcohol Use Disorder – Moderate | [ ]  | 305.70 | F15.10 | Stimulant-Related Disorder – Amphetamine-type substance – Mild |
| [ ]  | 303.90 | F10.20 | Alcohol Use Disorder – Severe | [ ]  | 304.40 | F15.20 | Stimulant-Related Disorder – Amphetamine-type substance – Moderate |
| [ ]  | 305.20 | F12.10 | Cannabis Use Disorder – Mild | [ ]  | 304.40 | F15.20 | Stimulant-Related Disorder – Amphetamine-type substance – Severe |
| [ ]  | 304.30 | F12.20 | Cannabis Use Disorder – Moderate | [ ]  | 305.1 | Z72.0 | Tobacco Use Disorder – Mild |
| [ ]  | 304.60 | F12.20 | Cannabis Use Disorder – Severe | [ ]  | 305.1 | F17.200 | Tobacco Use Disorder – Moderate |
| [ ]  | 305.50 | F11.10 | Opioid Use Disorder – Mild | [ ]  | 305.1 | F17.200 | Tobacco Use Disorder – Severe |
| [ ]  | 304.00 | F11.20 | Opioid Use Disorder – Moderate | [ ]  | 305.90 | F19.10 | Other (or Unknown) Substance Use Disorder – Mild |
| [ ]  | 304.00 | F11.20 | Opioid Use Disorder – Severe | [ ]  | 304.90 | F19.20 | Other (or Unknown) Substance Use Disorder – Moderate |
| [ ]  | 305.60 | F14.10 | Stimulant-Related Disorder – Cocaine – Mild | [ ]  | 304.90 | F10.20 | Other (or Unknown) Substance Use Disorder – Severe |
| [ ]  | 304.20 | F14.20 | Stimulant-Related Disorder – Cocaine – Moderate | [ ]  | 304.20 | F14.20 | Stimulant-Related Disorder – Cocaine – Severe |
|  |
| **Include any secondary Behavioral Health Diagnoses (If any):** |
|       |       |
|       |       |
|       |       |
|  |
| **Medical Diagnoses (If any):** |
|       |       |
|       |       |
|       |       |
|       |       |

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| **Reason for Referral:** |
| Self-care skills:  | [ ]  Personal hygiene,[ ]  Grooming[ ]  Nutrition | [ ]  Dietary planning[ ]  Food preparation[ ]  Self administration of medication | Other:       |
| Social Skills: | [ ]  Community integration activities[ ]  Developing natural supports[ ]  Developing linkages with and supporting the individual’s participation in community activities. | Other:       |
| 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. | Other:       |
| Other: |       |  |  |
|  |
| **Any additional information that you feel would be helpful in serving this individual:** |
|       |
| **Who is making this referral: [ ]** Self **[ ]** Family **[ ]** Case Manager **[ ]** Other |
| Contact Information of the person making referral (if not self):**Name:**       **Phone:**       |
|  |
| **Psychiatrist:**       | **Address:**       | **Phone:**       |
| **Therapist:**       | **Address:**       | **Phone:**       |
| **Primary Care:**       | **Address:**       | **Phone:**       |
| **I am referring this client for Psychiatric Rehabilitation Services (Clinician please check off this section for services)**  |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Referring Clinician’s Name & Credentials (Print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Referring Clinician’s Signature Date