

# Application for Psychiatric Rehabilitation Services

Humanim Behavioral Health Department

Psychiatric Rehabilitation Services (Day Program, Supported Living, and Supported Employment) are designed for adults and young adults with chronic and persistent mental illness to help them regain and maintain independence within the community. Services can include life skills teaching, intensive case management, in-home support, day program services, job placement and support services, and in some cases housing assistance.

This application must be completed in full and signed by a clinician. To qualify, the individual must:

- Have Medical Assistance.
- Be in active treatment with the referring provider (met at least twice) and remain in treatment while receiving Humanim services.
- Have experienced functional impairments for at least two years OR have a new-onset Category A diagnosis.
- Have had other service types determined inappropriate, and PRP is needed.

Completed applications may be emailed to BHAdmin@humanim.org, faxed to Behavioral Health Admin at 410-381-5317, or mailed to Humanim Behavioral Health Department, 6355 Woodside Ct., Columbia, MD 21046.

## SERVICES REQUESTED

- Referring for Psychiatric Rehabilitation Day Services (day program)
- Referring for Supported Living Services (in-home supports and case management)
- Check here if individual is between the ages of 18 and 26
- Referring for Supported Employment Services

**If referring for Supported Employment AND another service, provide justification for both:**

**If only a single visit has occurred prior to referral, explain the situation:**

## INDIVIDUAL INFORMATION

<b>Last Name *</b>	<b>First Name *</b>	<b>Middle Name</b>
<input type="text"/>	<input type="text"/>	<input type="text"/>

**Address**

<b>Home Phone</b>	<b>Mobile Phone</b>	<b>Email</b>
<input type="text"/>	<input type="text"/>	<input type="text"/>

<b>Sex</b>	<b>Pronouns</b>	<b>Race</b>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Date of Birth

Age

Social Security #

Medical Assistance #

MCO (if applicable)

Sources of Income

Amount of Income

## DSM-5 DIAGNOSIS

To qualify for services, the individual must meet one of the following DSM-5 diagnoses. Check all that apply.

### Category A Diagnosis

- |  |  |
|--|--|
| <input type="checkbox"/> F20.9 Schizophrenia                   | <input type="checkbox"/> F20.81 Schizophreniform Disorder    |
| <input type="checkbox"/> F25.0 Schizoaffective, Bipolar        | <input type="checkbox"/> F28 Schizoaffective, Depressive     |
| <input type="checkbox"/> F33.3 MDD Recurrent w/ Psychotic      | <input type="checkbox"/> F31.2 BP I Manic Severe Psychotic   |
| <input type="checkbox"/> F31.5 BP I Depressed Severe Psychotic | <input type="checkbox"/> F29 Other Specified Schizo Spectrum |
| <input type="checkbox"/> F22 Unspecified Schizo Spectrum       | <input type="checkbox"/> F22 Delusional Disorder             |

### Category B Diagnosis

- |  |  |
|--|--|
| <input type="checkbox"/> F33.2 MDD Recurrent Severe    | <input type="checkbox"/> F31.13 BP I Manic Severe              |
| <input type="checkbox"/> F31.4 BP I Depressed Severe   | <input type="checkbox"/> F31.0 BP I Hypomanic                  |
| <input type="checkbox"/> F31.9 BP I Hypomanic, Unspec. | <input type="checkbox"/> F31.9 BP I Unspecified                |
| <input type="checkbox"/> F31.81 Bipolar II Disorder    | <input type="checkbox"/> F60.3 Borderline Personality Disorder |

## DIAGNOSTIC CRITERIA WAIVER CONDITIONS

- Not competent to stand trial or not criminally responsible due to a mental disorder (Criminal Procedure, 3-101 et seq., Annotated Code of Maryland), receiving services recommended by a BHA/Maryland Department of Health evaluator, facility, or court order.
- In a Maryland State psychiatric facility for more than 3 months, requiring Residential Rehabilitation Program services upon discharge. Excludes individuals eligible for Developmental Disabilities Administration services.

## IMPAIRED ROLE FUNCTIONING

The individual demonstrates impaired role functioning for at least two years. At least three of the following must have been present on a continuing or intermittent basis.

- Marked inability to establish or maintain independent competitive employment.
- Marked inability to perform instrumental activities of daily living.
- Marked inability to establish or maintain a personal support system.
- Marked or frequent deficiencies of concentration, persistence, or pace.
- Marked inability to perform or maintain self-care.
- Marked deficiencies in self-direction.
- Marked inability to procure financial assistance to support community living.

### SOCIAL ELEMENTS IMPACTING DIAGNOSIS

Check all that apply.

- |                                      |   |   |   |
|--------------------------------------|---|---|---|
| <input type="checkbox"/> None        | <input type="checkbox"/> Access to Healthcare | <input type="checkbox"/> Housing Problems   | <input type="checkbox"/> Social Environment |
| <input type="checkbox"/> Educational | <input type="checkbox"/> Legal / Crime        | <input type="checkbox"/> Occupational       | <input type="checkbox"/> Homelessness       |
| <input type="checkbox"/> Financial   | <input type="checkbox"/> Primary Support      | <input type="checkbox"/> Other Psychosocial | <input type="checkbox"/> Unknown            |

### CO-OCCURRING SUBSTANCE USE DISORDER

Cannot be primary diagnosis. Check all that apply.

- |  |  |
|--|--|
| <input type="checkbox"/> F10.10 Alcohol UD Mild            | <input type="checkbox"/> F10.20 Alcohol UD Moderate      |
| <input type="checkbox"/> F10.20 Alcohol UD Severe          | <input type="checkbox"/> F12.10 Cannabis UD Mild         |
| <input type="checkbox"/> F12.20 Cannabis UD Moderate       | <input type="checkbox"/> F12.20 Cannabis UD Severe       |
| <input type="checkbox"/> F11.10 Opioid UD Mild             | <input type="checkbox"/> F11.20 Opioid UD Moderate       |
| <input type="checkbox"/> F11.20 Opioid UD Severe           | <input type="checkbox"/> F14.10 Stim. Cocaine Moderate   |
| <input type="checkbox"/> F14.20 Stim. Cocaine Severe       | <input type="checkbox"/> F15.10 Stim. Amphetamine Mild   |
| <input type="checkbox"/> F15.20 Stim. Amphetamine Moderate | <input type="checkbox"/> F15.20 Stim. Amphetamine Severe |
| <input type="checkbox"/> Z72.0 Tobacco UD Mild             | <input type="checkbox"/> F17.200 Tobacco UD Moderate     |
| <input type="checkbox"/> F17.200 Tobacco UD Severe         | <input type="checkbox"/> F19.10 Other SUD Mild           |
| <input type="checkbox"/> F19.20 Other SUD Moderate         | <input type="checkbox"/> F10.20 Other SUD Severe         |

### SECONDARY BEHAVIORAL HEALTH DIAGNOSES

Include any secondary Behavioral Health Diagnoses (if any):

### MEDICAL DIAGNOSES

Include Medical Diagnoses (if any):

### CURRENT MEDICATIONS

If the primary diagnosis is a mood disorder, list all medications used to treat it, including dosage and frequency. If the individual is not taking medications, explain why below.

**Current medications (name, dosage, frequency):**

**Explanation if not taking medications:**

**REASON FOR REFERRAL**

Check all that apply.

**Self-Care Skills**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Personal Hygiene | <input type="checkbox"/> Grooming         | <input type="checkbox"/> Nutrition                       |
| <input type="checkbox"/> Dietary Planning | <input type="checkbox"/> Food Preparation | <input type="checkbox"/> Self-Administration of Medicine |

**Social Skills**

- Community integration activities
- Developing natural supports
- Developing linkages with community activities

**Independent Living Skills**

- |  |  |
|--|--|
| <input type="checkbox"/> Skills for housing stability          | <input type="checkbox"/> Community awareness           |
| <input type="checkbox"/> Mobility and transportation           | <input type="checkbox"/> Money management              |
| <input type="checkbox"/> Accessing entitlements / resources    | <input type="checkbox"/> Health promotion and training |
| <input type="checkbox"/> Wellness self-management and recovery |  |

**Other Reason for Referral:**

**SUPPORTED EMPLOYMENT SERVICES**

Complete this section if applying for Supported Employment Services.

**Previous Employment**

**Start Date**

**Employer**

**Wages**

**Job Description**

**Employment Barriers**

- |   |   |
|---|---|
| <input type="checkbox"/> Communication                        | <input type="checkbox"/> Mobility and Transportation                |
| <input type="checkbox"/> Money Management                     | <input type="checkbox"/> Clothing / resources needed for employment |
| <input type="checkbox"/> Assistance in Maintaining Employment | <input type="checkbox"/> Criminal Background                        |

**Criminal Background Explanation:**

**SERVICES OFFERED OR ATTEMPTED PRIOR TO PRP REFERRAL**

- Targeted Case Management
- Individual and/or Group Therapy
- Peer Support Services
- Informal supports such as family

If any above were not offered or were unsuccessful, please explain:

Why ongoing outpatient treatment is not sufficient:

**ADDITIONAL INFORMATION**

Any additional information that you feel would be helpful in serving this individual:

**REFERRAL CONTACT INFORMATION**

<b>Name</b>	<b>Phone</b>
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**Referral Source (check one)**

- Inpatient
- Residential Crisis
- Mobile / Assertive Community Treatment
- Mental Health Residential Treatment Center
- Incarceration
- Treating Outpatient Provider

**PROVIDER INFORMATION**

**Psychiatrist**

<b>Name</b>	<b>Address</b>	<b>Phone</b>
<div style="border: 1px solid black; height: 20px;"></div>	<div style="border: 1px solid black; height: 20px;"></div>	<div style="border: 1px solid black; height: 20px;"></div>

**Therapist**

<b>Name</b>	<b>Address</b>	<b>Phone</b>
<div style="border: 1px solid black; height: 20px;"></div>	<div style="border: 1px solid black; height: 20px;"></div>	<div style="border: 1px solid black; height: 20px;"></div>

**Primary Care**

<b>Name</b>	<b>Address</b>	<b>Phone</b>
<div style="border: 1px solid black; height: 20px;"></div>	<div style="border: 1px solid black; height: 20px;"></div>	<div style="border: 1px solid black; height: 20px;"></div>

**REFERRING CLINICIAN INFORMATION**

The clinician must be a licensed mental health provider (Psychiatrist, CRNP-PMH, Licensed Psychologist, LCSW-C, LCPC, APRN-PMH, LCMFT, or LCADC). LGPC, LMFT, LGADC, LGPAT, and LMSW may refer only if in a formal clinical supervision arrangement with an approved supervisor. PA, RN-C, CAC-AD, and CSC-AD are not eligible to make referrals. The clinician must be enrolled in Medicaid.

<b>Clinician Name *</b>	<b>Credentials *</b>
<input type="text"/>	<input type="text"/>

**Supervisor (if applicable)**

**Agency Name**

<b>NPI Number *</b>	<b>Signature Date *</b>
<input type="text"/>	<input type="text"/>

**Referring Clinician Signature \***