



Email to [client.referrals@peponline.org](mailto:client.referrals@peponline.org)

Name of Consumer: \_\_\_\_\_

**SERVICE REQUEST:**

Name of Treating Licensed mental health provider: \_\_\_\_\_

Name of Agency( if Applicable)\_\_\_\_\_

Relationship to Consumer: \_\_\_ Self \_\_\_ Family \_\_\_ Friend/Peer \_\_\_ Professional

Is the licensed Provider enrolled as a provider in the Medicaid program Yes \_\_\_ No \_\_\_

If No- You will not be able to continue with Referral

Reason for referral: \_\_\_\_\_

Continuation of Services \_\_\_\_\_

Preferred Start Date: \_\_\_\_\_

Individuals referred for PRP must be referred from inpatient, residential crisis, mobile treatment/assertive community treatment, mental health RTC program, or from their treating outpatient mental health provider. Is this participant being referred from:

Ip/Crisis Res/mobile/Act/RCT \_\_\_ Outpatient provider \_\_\_ Neither \_\_\_

**\*\*If Neither Participant is not eligible for Services.\*\***

<p><b>Baltimore City</b></p> <p>___ Psychiatric Rehab Program (Day Program)</p> <p>___ Substance Abuse Treatment</p> <p>___ Supported Employment</p> <p>___ Intensive Case Management</p> <p>___ Homeless Outreach Services</p> <p>___ Assertive Community Treatment (ACT) ___</p> <p>Forensic Assertive Community Treatment (ACT)</p> <p>___ Residential Rehabilitation Program* * All residential referrals must be made with the local Core Service Agency</p> <p>Other Services or Special Needs:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><b>Baltimore County</b> ___ Assertive Community Treatment (ACT)</p> <p><b>Montgomery County</b> ___ Assertive Community Treatment (ACT)</p> <p><b>Anne Arundel County</b> ___ Assertive Community Treatment (ACT) ___ Assertive Community Treatment (Homeless)</p> <p><b>Prince George's County</b> Assertive Community Treatment (ACT)</p> <p>___ Assertive Community Treatment (ACT)</p> <p>How did you hear about us?</p> <p>___ Word of mouth</p> <p>___ Current/former consumer</p> <p>___ Family of consumer</p> <p>___ Local behavioral health authority</p> <p>___ 211</p> <p>___ Web search</p> <p>___ Other: _____</p> <p>Referral Method: ___ Fax ___ e-mail ___ Walk-in ___</p> <p>Other: _____</p>
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Consumer Name: \_\_\_\_\_ Date completed: \_\_\_\_\_

## PERSONAL INFORMATION

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ M.I. \_\_\_\_\_

SSN: \_\_\_/\_\_\_/\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Marital Status: \_\_\_\_\_

Residency Status: \_\_\_ U.S. Citizen \_\_\_ Permanent Resident \_\_\_ Other: \_\_\_\_\_

Veteran Status: Yes \_\_\_ No \_\_\_

Ethnicity: \_\_\_ Hispanic or Latino \_\_\_ NOT Hispanic or Latino \_\_\_ Declined

Preferred Language: \_\_\_\_\_

Race: \_\_\_ Asian \_\_\_ Black or African American \_\_\_ White \_\_\_ Native Hawaiian \_\_\_ American Indian  
\_\_\_ Alaskan Native \_\_\_ Declined

Identification: Birth Certificate: Y \_\_\_ N \_\_\_ Social Security Card: Y \_\_\_ N \_\_\_

Photo ID: Yes \_\_\_ No \_\_\_ Insurance Card: Yes \_\_\_ No \_\_\_

Insurance

Does the participant have Medicaid (Including SLMB or QMB)? Yes or No

Medicaid # \_\_\_\_\_ Medicare #: \_\_\_\_\_

Other Medical Insurance: \_\_\_\_\_

**If not, does the participant meet one of the four criteria below?**

### Additional Exception Criteria

On conditional Release \_\_\_ Discharged from inpatient Psych within last 6 months \_\_\_

Released from Jail within the last 6 months \_\_\_ discharged from a RRP in the last 6 months \_\_\_ None \_\_\_

**\*\*If Participant does not have Medicaid, they must meet at least one of the criteria above to be eligible for PRP, otherwise the service cannot be authorized for PRP.\*\***

## HEALTH INFORMATION

Diagnoses (include mental health and somatic health and associated ICD-10 Code):

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If Client doesn't have Category A or Category B diagnosis (see attached) the client must meet the additional exception criteria (see above). If not PRP Services will not be authorized.

Does the client have any health concerns that haven't been diagnosed?

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Allergies (Include medication allergies): \_\_\_\_\_

Type of reaction(s): \_\_\_\_\_

Consumer Name: \_\_\_\_\_

**Occupational**

Is the consumer employed?

Yes or No

Has the consumer been referred to supportive employment?

Yes or No

If consumer has supported employment services. Please justify the need for PRP services below.

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Please list any medications for Mood disorder or Bipolar \_\_\_\_\_

Is This individual on medication? If yes, please fill out chart below.(attach Medication list if needed)

medication	dosage	Frequency

If not, please explain why the participant is not on medication \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Printed Name of referral source: \_\_\_\_\_ Date: \_\_\_\_\_

Credentials: \_\_\_\_\_

Signature: \_\_\_\_\_

NPI# \_\_\_\_\_

\* Signature , NPI # and credentials are required if referring to Psychiatric Rehab Program (Day Program)

Consumer Name: \_\_\_\_\_

Is the primary reason for the individual's impairment due to an organic process of syndrome, intellectual disability, a neurodevelopmental disorder or neurocognitive disorder?

Yes                      No

Has the individual been found not competent to stand trial or not criminally responsible and is receiving services recommended by a MD Department of Health Evaluator?

Yes                      NO

Is the individual eligible for full funding for DDA Services?

Yes                      NO

Duration of current episode of treatment provided to this individual (circle one)

- Less than 1 month
- 2-3 months
- 4-6 months
- 7-12 months
- More than 12 months

Has the individual received PRP services from at least one other PRP within the past year?

Yes                      No

How long has the individual been in PRP services at this agency? (circle one)

- New referral
- Less than 1 year
- 1-2 years
- 2+years

**Status of Less Intensive Level of Treatment**

**Have Peer supports and other informal supports such as family been tried?**

**Yes or No**

**Which of the following less intense services have been tried?**

**Group therapy\_\_\_\_\_ Targeted Case Management\_\_\_\_\_**

**If not please explain any unsuccessful attempts or reason why no attempt?**

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Consumer Name: \_\_\_\_\_

**Functional Criteria:**

Has the participant demonstrated marked functional impairments for the last 2 years?

Yes or no

Does the participant have impairments related to the priority population diagnosis in 3 or more of the functional areas listed below?

Yes or no

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.

## Functional Criteria Questions

Complete at least three of Numbers 1-7.

1. Evidence of marked inability to establish or maintain competitive employment. (Explain)

1A Describe the symptoms of this priority population diagnosis that affect the participant's functioning

1B Describe how, specifically these symptoms impair the participants' functioning

1C Provide specific concrete examples of THIS participant impaired function

2. Evidence of marked inability to perform instrumental activities of daily living (e.g. shopping, meal preparation, laundry, basic housekeeping, medication management, transportation and money management). (Explain)

2A Describe the symptoms of this priority population diagnosis that affect the participant's functioning

2B Describe how, specifically these symptoms impair the participants' functioning

2C Provide specific concrete examples of THIS participant impaired function

3. Evidence of marked inability to establish/maintain a personal support system. (Explain)

3A Describe the symptoms of this priority population diagnosis that affect the participant's functioning

3B Describe how, specifically these symptoms impair the participants' functioning

Consumer Name: \_\_\_\_\_

**3C Provide specific concrete examples of THIS participant impaired function**

4. Evidence of deficiencies of concentration/persistence/pace leading to failure to complete tasks. (Explain)

**4A Describe the symptoms of this priority population diagnosis that affect the participant's functioning**

**4B Describe how, specifically these symptoms impair the participants' functioning**

**4C Provide specific concrete examples of THIS participant impaired function**

5. Evidence of unable to perform self-care, hygiene, grooming, nutrition, medical care, safely. (Explain)

**5A Describe the symptoms of this priority population diagnosis that affect the participant's functioning**

**5B Describe how, specifically these symptoms impair the participants' functioning**

**5C Provide specific concrete examples of THIS participant impaired function**

6. Evidence of marked deficiencies in self-direction, shown by inability to plan, initiate, organize and carry out goal directed activities. (Explain)

**6A Describe the symptoms of this priority population diagnosis that affect the participant's functioning**

**6B Describe how, specifically these symptoms impair the participants' functioning**

**6C Provide specific concrete examples of THIS participant impaired function**

7. Evidence of marked inability to procure financial assistance to support community living. (Explain)

**7A Describe the symptoms of this priority population diagnosis that affect the participant's functioning**

**7B Describe how, specifically these symptoms impair the participants' functioning**

**7C Provide specific concrete examples of THIS participant impaired function**

Consumer Name: \_\_\_\_\_

List specific ways in which PRP services are expected to help this individual.

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Printed Name of referral source: \_\_\_\_\_ Date: \_\_\_\_\_

Credentials: \_\_\_\_\_

Signature: \_\_\_\_\_

NPI# \_\_\_\_\_

\* Signature, NPI # and credentials are required if referring to Psychiatric Rehab Program (Day Program)

## **Category A diagnosis**

**F20.0- Paranoid Schizophrenia**  
**F20.1- disorganized schizophrenia**  
**F20.2- Catatonic Schizophrenia**  
**F20.3- undifferentiated Schizophrenia**  
**F20.5- Residual Schizophrenia**  
**F20.81- Schizophreniform disorder**  
**F20.89- Other schizophrenia**  
**F20.9- schizophrenia, unspecified**  
**F25.0- schizoaffective disorder, bipolar type**  
**F25.1- schizoaffective disorder, depressive type**  
**F25.8- Other schizoaffective disorders**  
**F25.9- schizoaffective disorder, unspecified**  
**F22—Delusional disorder**  
**F28- other psychotic disorder**  
**F29- Unspecified psychosis**  
**F31.2 Bipolar 1 disorder, manic severe w/psychotic ft**  
**F31.5 Bipolar 1 disorder, depressed, manic, severe with psychotic ft**  
**F31.64- Bipolar 1 disorder, mixed, severe with psychiatric ft**  
**F33.3 MDD, recurrent, severe with psychotic ft**

## **Category B diagnosis**

**F31.0- bipolar 1 disorder, hypomanic**  
**F31.13- Bipolar 1 disorder, manic severe**  
**F31.4-bipolar 1 disorder, depressed, severe**  
**F31.63- bipolar disorder, mixed, severe w/o psychotic**  
**F31.9-bipolar disorder, unspecified**  
**F33.2- MDD, recurrent, severe, w/o psychotic ft**  
**F60.3- Borderline personality disorder**