Springboard COMMUNITY SERVICES
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Psychiatric Rehabilitation Program (PRP) Referral Form

☐ **Adult Psychiatric Rehabilitation Program** ☐ **Minor Psychiatric Rehabilitation Program**

CLIENT INFORMATION

Date of Referral:_____

Legal Name: _____ Date of Birth: _____Social Security Number:_____
(First) (Middle Initial) (Last)

Address: _____City: _____ State: _____ Zip Code: _____☐ Currently homeless/no permanent address

Phone: _____ Type: ☐ Cell ☐ Home ☐ Work Secondary Contact: _____ Type: ☐ Cell ☐ Home ☐ Work

Email: _____ Language(s) Preference: _____

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed ☐ Separated ☐ I Choose Not to Disclose

Is the client a minor? ☐ Yes ☐ No Does Individual have a: Legal Guardian ☐ Yes ☐ No

Parent/Guardian Name: _____ best contact number:_____ Power of Attorney ☐ Yes ☐ No

Has Guardian been notified of this referral? (Please provide the guardianship documents or POA) ☐ Yes ☐ No

Gender identity: ☐ Male ☐ Female ☐ Gender Fluid ☐ Transgender Male ☐ Transgender Female ☐ Non-Binary

☐ Other: _____ ☐ I Choose Not to Disclose

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ I Choose Not to Disclose

Race: ☐ Black/African-American ☐ White/Caucasian ☐ Asian ☐ Native Hawaiian ☐ Pacific Islander

☐ American Indian/Alaskan Native ☐ Other: _____ ☐ I Choose Not to Disclose

Income Sources and Amounts: SSI_____, SSDI_____, Food Stamps_____, Other_____ Rep Payee: ☐ Yes ☐ No

Insurance: Medical Assistance (Medicaid) #:_____, Medicaid REQUIRED for PRP Services to be covered

What is the primary Public Behavioral Health System specialty mental health DSM 5 diagnosis [F code]?_____

Current Legal Status (i.e. parole, probation, conditional release, etc)_____

Primary Behavioral Health reason for referral:_____

_____

Barriers to Independence:_____

Somatic Health and needs for Assistive Technology:_____

Risk Taking Behavior (Include history of violence, aggression and substance abuse):_____

_____

Highest Level of Education Completed: ☐ Some High School ☐ High School Diploma/GED ☐ Associate's ☐ Bachelor's

Name of current or last school:_____

☐ Master's ☐ Doctorate ☐ Trade/Technical/Vocational ☐ I Choose Not to Disclose I am Currently: ☐ Employed Full-Time ☐ Employed Part-Time ☐ Unemployed ☐ Full-Time Student ☐ Self-Employed ☐ Retired

Referral Source: Maryland Behavioral Health Administration REQUIRES PRP referrals are from licensed mental health professionals.

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Name, Credentials: _____ **Signature:** _____

Facility (if applicable): _____ **Phone & Email:** _____

The Maryland Behavioral Health Administration requires a referral by a mental health professional for admission in to the Psychiatric Rehabilitation Program (PRP). These referrals must be provided every six months to ensure medical necessity for clients receiving services. In addition, these providers are required to maintain up-to-date diagnosis for each participant. This document permits mental health professionals to submit both requirements in this referral.

I am verifying that _____ meets the eligibility criteria for the Psychiatric Rehabilitation Program.
Services needed include assessment and continued on-site and/or offsite services to facilitate the client's wellness and recovery to aide in community integration and improved quality of life.

Please briefly describe the client's need for PRP Services: _____

Please check all that apply: [Youth]

- ☐ **Marked safety risk to self or others**
- ☐ **Marked inability to complete or engage in age appropriate behaviors like communication, hygiene, following and understanding directions, etc**
- ☐ **Marked risk to youth's current placement** (family of origin, foster care, etc.)
- ☐ **Marked inability to perform or maintain self-care** (hygiene, grooming, nutrition, medical care, personal safety)
- ☐ **Marked deficiencies in self-direction**, characterized by an inability to independently plan, initiate, organize, and carryout goal-directed activities
- ☐ **Demonstration of ability to improve managing emotions, responding to others** (authority figures) **and general behaviors**

_____.

Please check all that apply: [Adults]

- ☐ **Marked inability to establish or maintain independent competitive employment,**
- ☐ **Marked inability to perform instrumental activities of daily living** (shopping, meal preparation, laundry, basic housekeeping, medication management, transportation, and money management)
- ☐ **Marked inability to establish or maintain a personal support system**, characterized by social withdrawal or isolation, interpersonal conflict, or socia behavior
- ☐ **Marked inability to perform or maintain self-care** (hygiene, grooming, nutrition, medical care, personal safety)
- ☐ **Marked deficiencies in self-direction**, characterized by an inability to independently plan, initiate, organize, and carry out goal-directed activities
- ☐ **Marked inability to procure financial assistance to support community living,**

Authorizations require a DSM diagnosis. Please provide the information below for authorization:
Primary DSM Behavioral Health Diagnosis
Code_____ Description_____

Additional DSM Behavioral Health Diagnosis
Code_____ Description_____
Code_____ Description_____

***ADULT PRP Referrals Require a Category A or B DSM Diagnosis *MINOR PRP Referrals Requires ANY DSM Diagnosis with medical necessity**

CATEGORY A	CATEGORY B

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☐ 295.90/F20.9 Schizophrenia	☐ 296.44/F31.2 Bipolar I Disorder, Current or Most Recent Episode Manic, Severe w/ Psychotic Features
☐ 295.40/F20.81 Schizophreniform Disorder	☐ 296.53/F31.4 Bipolar I Disorder, current or most Recent Episode Depressed, Severe
☐ 295.70/F25.0 Schizoaffective Disorder, Bipolar Type	☐ 296.54/F31.5 Bipolar I Disorder, Current or Most Recent Episode Depressed, Severe, w/Psychotic Features
☐ 295.70/F25.1 Schizoaffective Disorder, Depressive Type	☐ 296.03/ F.31.63 Bipolar I Disorder, current or most recent episode mixed, severe without psychotic features
☐ 298.8/F28 Other Specified Schizophrenia Spectrum and Other Psychotic Disorder	☐ 296.89/F31.81 Bipolar II Disorder
☐ 298.9/F29 Unspecified Schizophrenia Spectrum and Other Psychotic Disorder	☐ 296.7/F31.81/ Bipolar I Disorder, unspecified
☐ 297.1/F22 Delusional Disorder	☐ 301.22/F21/ Schizotypal Personality Disorder
☐ 296.33/F33.2 Major Depressive Disorder, recurrent, severe, without psychotic features	☐ 301.83/F60.3 Borderline Personality Disorder
☐ 296.34/F33.3 Major Depressive Disorder, Recurrent Episode, w/Psychotic Features	
☐ 296.40/F31.0 Bipolar I Disorder, current or most recent episode hypomanic	
☐ 296.43/F31.13 Bipolar I Disorder, current or most recent episode manic, severe	

Medical Diagnosis:_____

_____ Date_____
Signature and Title/Licensure of Mental Health Professional

_____
Clinician Printed Name

_____
Masters or Graduate Level Supervisor Name, if applicable

Consent For Release of Confidential Information

I, _____, authorize Springboard Community Services

[client, or parent/guardian]

and _____

[individual/organization name and address]

To disclose to each other the following specific information:

(It may be released or obtained in written, verbal, audio-visual or electronic forms]

_____Psychological Evaluation

_____Educational Evaluation

_____Psychiatric Evaluation

_____Case Summary/Progress Notes

_____Social History

_____Treatment/Service Plan

_____Vocational Evaluation

_____IRP/WRP

_____Medical Data

_____Ongoing Communication

_____Employment Issues

_____Other (Specify)

_____School [teachers, advisors, counselors, tutors-IEP _____

The purpose of this consent is coordination of services. This consent will expire one year from date signed.

I have been informed of the type of information being sought, and its use to obtain approval for PRP services and effective treatment planning. I understand that the following may include treatment information for mental and/or physical illness, counseling or treatment for drug and/or alcohol abuse, human immunodeficiency [HIV] infection, including acquired immunodeficiency syndrome [AIDS]. I understand that my records are protected under Federal Law, and cannot be re-disclosed without my express or written consent, unless otherwise permitted in accordance with Federal Law and Regulations. I also understand that I may revoke this consent at any time, except to the extent that action has been taken on it.

Date of Birth:_____ Date Signed: _____

Client, Parent/Guardian signature: _____

Complete Client address:

_____ _____ ____ _____

[Street Address] *[City]* *[State]* *[Zip}*