HealthPort

208 E Main Street, Ste C
Salisbury, MD 21801
P: 410-341-3420x1 F: 410-651-4872
referral@HealthPort.org

Referral for Psychiatric Rehabilitation Program and Vocational Services

- **Please fill out all the pages. Submit this form via fax to 410-651-4872 or email to referral@HealthPort.org**
- All referrals must meet eligibility criteria in that they have a diagnosis approved by the ASO for authorization for PRP services. See attachment for list of approved diagnoses.
- Within 5 working days of receiving the completed referral the PRP will arrange for the applicant to visit to receive a face to face screening assessment to determine eligibility, rehabilitation, service needs, and willingness to participate. Also at this time, a determination will be made of the PRP's ability to address this individual's needs.
- Within 10 working days of the screening assessment, the individual will be notified whether the PRP: A. Accepts the individual; B. Will accept the individual following an updated review of the individual's eligibility, when the program capacity permits; C. Denies PRP services; D. Will accept the individual following an updated review of the individual's eligibility, after the individual's discharge or release from an inpatient facility or detention center.
- Within 10 working days of the PRP's acceptance of the individual, PRP staff will begin the enrollment process in accordance with the PRP regulations.
- Within 10 working days of the PRP's denial of the individual the PRP staff will notify the individual in writing according to the PRP regulations.

Services being referred for:

☐ **Day Program/ PRP** ☐ **Community Support PRP** ☐ **Vocational Program/Supported Employment**

Please answer the following as they are required for authorization to PRP services:

1. Education History; Highest level of education achieved: _____
2. Employment History: _____
   _____
3. Arrested or Incarcerated in last 30 Days? If yes, include charges: _____
   _____

Release/Authorization:

I, _____, authorize the release/exchange of all available information between the following agencies/individuals to support my application to HealthPort. This includes information that may pertain to denial or termination, including the reason for these actions, and when appropriate discharge plans. By my signature I understand and am agreeing to this Application for Rehabilitation Services. This release/authorization is effective for 90 days.

Emergency Contact: _____
Treatment Providers: Mental Health and Somatic: _____
Entitlement Agency: _____

Signature of Applicant: _____ Date: _____

_____ _____
Referral Source Signature (Must be Mental Health Professional, Include Credentials for PRP Referrals) Date

Applicant's Name: _____
(Last) (First) (MI)

Address: _____

Home Phone: _____ Mobile Phone: _____

Date of Birth: _____ Social Security Number: _____

Gender: _____ Gender Identity: _____ Race _____ Marital Status: _____

Current Entitlements and Income: Fill in amounts and/or Insurance ID

SSI: _____ SSDI: _____ Other Income: _____

Medicaid (MA): _____ Medicare: _____ Other Insurance: _____

Referral Source Name: _____ Contact Number: _____

Agency: _____ Phone Number: _____

Mental Health Provider: _____ NPI: _____

Referral Source Type: ☐ Inpatient/ Crisis Residential/ Residential Treatment Center/ Incarceration/ Assertive Community Treatment ☐ Outpatient Mental Health

Is the client actively enrolled in mental health treatment? ☐ Yes ☐ No

Has the provider met with the client at least two times? ☐ Yes ☐ No

Please indicate which service types the client has tried: ☐ Individual Therapy ☐ Group Therapy ☐ Targeted Case Management ☐ Peer Support Services ☐ Informal Supports- Such as family

If none, why not? _____

Primary Contact (Applicant, therapist, family, friend, other)- Name, phone number, and relationship

_____

Current Psychiatric Diagnoses:	**ICD 10 Code**
Primary: _____	_____
Secondary: _____	_____
Tertiary/Additional: _____	_____
_____	_____
Medical: _____	_____
_____	_____

Psychiatric Hospitalizations: Number of Psychiatric Hospitalizations (Lifetime) _____

Dates, Locations, Length of Stay: _____

_____

_____

Primary Care Provider: Name & Contact Information**:** _____

Significant Somatic Issues: _____

_____

All Current Medications: Prescriptions, Over the Counter, and Supplements. Please include full list

Name/Dosage/Frequency/Prescriber

_____

_____

_____

_____

Currently Able to take medications: Independently ☐ With Reminders ☐ With Daily Supervision ☐
Refuses Medication: ☐ No Medications Currently Prescribed ☐
Comments: _____
_____

Functional Impairments: Please comment on the areas below, provide specific examples, evidence, or symptoms for each:

1. Does the participant have marked inability to establish or maintain competitive employment?
   ☐ Yes ☐ No
   _____
   _____
2. Does the participant have marked inability to perform instrumental activities of daily living, like shopping, meal preparation, laundry, housekeeping, medication management, transportation, or money management?
   ☐ Yes ☐ No
   _____
   _____
3. Does the participant have marked inability to establish/maintain a personal support system? Who is in the current support system?
   ☐ Yes ☐ No
   _____
   _____
4. Does the participant have deficiencies of concentration/persistence/pace leading to failure to complete tasks?
   ☐ Yes ☐ No
   _____
   _____
5. Is the participant unable to perform self-care (hygiene, grooming, nutrition, medical care, safety)?
   ☐ Yes ☐ No
   _____
   _____
6. Does the participant have marked deficiencies in self-direction, shown by inability to plan, initiate, organize, and carry out goal-directed activities?
   ☐ Yes ☐ No
   _____
   _____
7. Does the participant have marked inability to procure financial assistance to support community living?
   ☐ Yes ☐ No
   _____
   _____
8. Has the client ever been enrolled in Targeted Case Management:
   ☐ Yes ☐ No
   _____
   _____
9. Does the client participate in Peer Support Services (AA/NA, Group Therapy, Peer Supports, IOP, other):
   ☐ Yes ☐ No
   _____
   _____

Other evidence of marked impairment that prevent successful community living:

_____

_____

_____

_____

_____

Legal History/Forensic Involvement

History of Arrest: Yes ☐ No ☐ On Probation or Parole ☐ Yes ☐ No

Parole/Probation Officer & Phone: _____

List Any Reported Convictions: _____

_____

Has applicant ever been found NCR? Yes ☐ No ☐ Currently or Planned for Conditional Release ☐ Yes ☐ No

Substance Use/Abuse History:

Current Substance Use: Period of Use, Frequency/Cost, Route: _____

_____

Historical Substance Use: Dates of Last Use, Amount, Route: _____

_____

Substance Use Treatment History: Include dates and Locations

Support and Recovery Programs: _____

Formal Detox: _____

Inpatient Services: _____

Outpatient Services: _____

Risk Assessment: (Frequency, date of last incident, severity of incident)

Suicide Attempt: _____

Suicidal Ideation: _____

Self-Harm: _____

Aggressive Behavior/Violence: _____

Homicidal Ideation: _____

Fire-Setting: _____

Activities of Daily Living: Completes Independently: ☐ Needs Significant Support ☐ Needs Moderate Support ☐

Current Daily Activities: Recreation/Leisure/Social: _____

_____

Previous PRP/RRP Involvement? Yes ☐ No ☐ If Yes, Locations/Programs/ Reasons for Termination:

_____

_____

Consumer Provider Preference: _____

Cultural Preference of Consumer: _____

Specific ways that program services are expected to help this individual: _____

_____

_____

_____

Is Consumer in Agreement with PRP Referral? ☐ Yes ☐ No If No, Please Explain: _____

_____