

TIDEMARK BEHAVIORAL HEALTH

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◆◆ Adult PRP Referral Form ◆◆

Date of Referral : _____

Medicaid #:	_____
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Name:		Date of Birth:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/>
Phone #:		Email:		
Address:				

Clinical Information:	
The Adult has been engaging in active, documented, outpatient in total for: _____ years _____ months	Psychiatric hospitalization in the last 6 months? <input type="checkbox"/> No <input type="checkbox"/> Yes- Dates: _____
Duration of <i>current</i> episode of treatment provided:	Current frequency of treatment:

Mental Health Diagnosis : *Client must have a Category A or B diagnosis to be eligible for PRP services*

Behavioral Diagnosis- Category A: <input type="checkbox"/> <i>Does NOT have a Category A Diagnosis (Skip to Category B)</i>					
	F20.0	Paranoid Schizophrenia		F22.0	Delusional Disorders
	F20.1	Disorganized Schizophrenia		F25.0	Schizoaffective Disorder, Bipolar Type
	F20.2	Catatonic Schizophrenia		F25.1	Schizoaffective Disorder, Depressive Type
	F20.3	Undifferentiated Schizophrenia		F25.8	Other Schizoaffective Disorder
	F20.5	Residual Schizophrenia		F25.9	Schizoaffective Disorder, unspecified
	F20.81	Schizophreniform Disorder		F28.0	Other Psychotic Disorder
	F20.89	Other Schizophrenia		F29.0	Unspecified Psychosis
	F20.9	Schizophrenia, unspecified			
	F31.2	Bipolar I Disorder, current episode manic, severe with psychotic features		F31.64	Bipolar I Disorder, current episode mixed, severe with psychotic features
	F31.5	Bipolar I Disorder, current episode depressed, severe with psychotic features		F33.3	Major Depressive Disorder, recurrent, severe with psychotic features

Behavioral Diagnosis: <i>Category B</i>					
	F31.0	Bipolar I Disorder, current episode hypomanic		F31.81	Bipolar II Disorder
	F31.13	Bipolar I Disorder, current episode manic, severe without psychotic features		F31.9	Bipolar Disorder, unspecified
	F31.4	Bipolar I Disorder, current episode Depressed, severe without psychotic features		F33.2	Major Depressive Disorder, recurrent, severe without psychotic features
	F31.63	Bipolar I Disorder, current episode mixed, severe without psychotic features		F60.3	Borderline Personality Disorder

Presenting Symptoms: (Please include history of SI and HI)

If patient is on medication for a mood disorder, please list here including dosage and frequency: (If they are not taking medication, please explain why they are not on medication.)

Does the Adult speak English without assistance? No, Yes

Risk Level: * Is there a Sexual Offender or Domestic Violence in the home? No

Suicidal Ideation Suicidal Plan Previous Suicide Attempt Homicidal Ideation Homicidal plan

Is the participant enrolled with one of the following? Medicaid, Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB)

Does the participant meet one of these four criteria? Discharged from inpatient Psychiatric within the last 6 months, On conditional release from state hospital, Discharged from a RRP within the last 6 months, Released from jail within the last 6 months, None

Is the individual currently enrolled in SSI/SSDI? No, Yes, Unknown

Is the participant eligible for fully funded Developmental Disabilities Administration services? No, Yes

Is the primary reason for the participant's impairment due to an organic process or syndrome, intellectual disability, a neurodevelopmental disorder or neurocognitive disorder? No, Yes

Has the individual been found not competent to stand trial or not criminally responsible and is receiving services recommended by a Maryland Department of Health Evaluator? No, Yes

Has the participant demonstrated marked functional impairments for at least 2 years? No Yes

Does the participant have a new onset (within the last 6 months) Category A diagnosis? No Yes

Functional Impairments- Individuals **MUST** experience *at least 3* of the below *within the last 3 months* and it must relate back to their primary mental health diagnosis.

Inability to establish or maintain competitive employment

Inability to perform instrumental activities of daily living (shopping, meal preparation, medication management, transportation, and money management)

Inability to establish and/or maintain a personal support system

Deficiencies of concentration, persistence or pace leading to failure to complete tasks

Inability to perform or maintain self-care (hygiene, grooming, nutrition, medical care, safety) Deficiencies in self-direction, shown by inability to plan, initiate, organize, and carry out goal directed activities Inability to procure financial assistance to support community living

Emotional disturbance has resulted in significant psychological or social impairments that cause serious problems with peer relationships and/or family members.

Evidence- *Please provide a clinical narrative explaining the reasons for PRP referral with specific examples.*

Why is ongoing outpatient treatment not sufficient to address concerns?

Comments: *Please address any additional needs and/or areas of concern.*

Alternative Service & Transition Considerations: *(Please list below attempts and outcomes of any efforts to serve this individual through less formal means such as peer support or family.)*

Target Case Management Individual and/or Group Therapy
 Peer Support Services Informal Support, such as Family

Note: PRP may not routinely be provided in conjunction with: Mobile Treatment Services (MTS)/Assertive Community Treatment (ACT), Adult Targeted Case Management (TCM), Inpatient, MH-Residential Treatment Center (RTC), Residential SUD Treatment Level 3.3, Residential SUD Treatment Level 3., Residential SUD Treatment Level 3.7, Residential SUD Treatment Level 3.7WM, SUD IOP, SUD PHP, MH IOP, MH PHP, Residential Crisis.

Referral Contact: *If LMSW or LGPC, please include your clinical supervisor's name, credentials, & Medicaid Affiliate NPI number further below. (LMSW's must be signed off by an LCSW-C & LGPC's must be signed off by an LCPC)*

What type of provider is making the referral?

Inpatient Residential Crisis Mobile Community Treatment Incarceration
 Mental Health Residential Treatment Center Form of treating Outpatient Provider

Must have an LCPC, LCSW-C, Psychiatrist, or Psychologist complete the Clinical Supervisor fields below if you are an LMSW or LGPC

Clinician & Credentials/ Agency:			
Medicaid Affiliate NPI Number:			
Referral Contact #:		Email:	
Date:		Signature:	

Clinical Supervisor & Credentials:			
Medicaid Affiliate NPI Number:			
Supervisor Contact #:		Email:	
Date:		Signature:	

**** Please email to info@tidemarkinterventions.com or fax to 1 (800) 847-6028 ****