carelon

Request for Psychiatric Rehabilitation Program - Adult

Please upload form on Provider Connect with your request for services

Participant Name: _____ Participant DOB: _____

Requested Service: __ On-Site __ Off-Site __ Blended

Is the participant currently enrolled in SSI/SSDI? __ Yes __ No

Is the participant eligible for full funding for DDA services? __ Yes __ No

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

Has the participant been found not competent to stand trial or not criminally responsible and is receiving services recommended by a MDH Evaluator? __ Yes ___ No

Is the participant in a Maryland State psychiatric facility with a length of stay of more than 3 months who requires RRP upon discharge? (select No if participant is eligible for DDS) ___ Yes ___ No

Is the participant on medication? __ Yes __ No; If no, why are medications not part of the treatment? _____

Clinical Information:

Participant is being referred from: __ IP/Crisis Res/Mobile/ACT/Incarceration __ Outpatient __ Neither

Is participant currently receiving MH treatment from a licensed mental health provider? __ Y __ N

Is the licensed mental health provider enrolled as a provider in the Medicaid program? __ Y ___ N

Name of treating provider: _____ Date of Referral: _____

Provider Credentials: _____ Phone: _____ Email: _____

Is the referral source in some way paid by or receiving other benefits from the PRP program? __ Yes __ No

Duration of current episode of treatment: _____

Current frequency of outpatient clinical treatment: _____

Why is ongoing outpatient treatment not sufficient to address concerns? _____

If the participant is currently in treatment or receiving services from one of the services listed below, attach a transition plan with your submission or explain why both services are needed.

Mobile Treatment/ ACT	Targeted Case Management	Inpatient	MH-RTC
SUD Level 3.3, 3.5, 3.7, 3.7WM	SUD IOP	SUD PHP	MH IOP
MH PHP	Residential Crisis		

Have any of the following less intensive levels of treatment been tried? If yes, explain why they have not been sufficient. If no, what is the reason it has not been tried?

Peer or other informal supports: __ Y __ N

Group Therapy: __ Y __ N

Targeted Case Management: __ Y __ N

Explanation: _____

_____

Functional Criteria

Does participant have a new onset (within past 6 months) diagnosis? __ Y __ N

Has participant had impairments related to the Priority Population diagnosis in 3 or more of the functional areas listed below over the last 2 years? __ Y __ N

Check all that apply and list objective evidence, including **description of the symptoms, how they impair functioning, & concrete examples of the participant's impaired function**.

__ Marked inability to establish or maintain competitive employment

Evidence: _____

_____

__ Marked inability to perform instrumental activities of daily living (e.g. shopping, meal prep, laundry, basic housekeeping, medication management, transportation, money management)

Evidence: _____

_____

__ Marked inability to establish/maintain a personal support system

Evidence: _____

_____

__ Deficiencies of concentration / persistence / pace leading to failure to complete tasks

Evidence: _____

_____

__ Unable to perform self-care (hygiene, grooming, nutrition, medical care, safety)

Evidence: _____

_____

__ Marked deficiencies in self-direction, shown by inability to plan, initiate, organize & carry out goal-directed activities

Evidence: _____

_____

__ Marked inability to procure financial assistance to support community living

Evidence: _____

_____