



Request for Psychiatric Rehabilitation Program – Child/Adolescent/TAY

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 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

Will the participant’s level of cognitive impairment, current mental status or developmental level impact their ability to benefit from PRP? Yes No

Does the participant meet criteria for a higher level of care than PRP? Yes No

Have family or peer supports been successful in supporting this youth? Yes No

Clinical Information:

Is participant currently receiving mental health outpatient or inpatient treatment? 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? Y N

Current frequency of treatment being provided to this participant: _____

How long has participant been engaged in active, documented outpatient treatment? _____

In the past 3 months, how many ER visits has the youth had for psychiatric care? _____

Is the participant transitioning from an inpatient, day hospital or residential treatment setting to a community setting? Y N

Does the participant have a Targeted Case Management referral or authorization: Y N

Has medication been considered for this participant? Not considered Considered and Ruled Out
 Ongoing Initiated and Discontinued

Functional Criteria

Within the past 3 months, the emotional disturbance has resulted in: *(Check all that apply and list objective evidence)*

A clear, current threat to the participant’s ability to be maintained in their customary setting.

Evidence: _____

An emerging risk to the safety of the participant or others.

Evidence: _____

Significant psychological or social impairments causing serious problems with peer relationships and/or family members

Evidence: _____

What evidence exists to show that the current intensity of outpatient treatment is insufficient to reduce symptoms and functional behavioral impairments resulting from mental illness?: _____

Has a crisis plan been completed with family and/or guardian? Y N

Has an individual treatment plan / individual rehabilitation plan been completed? Y N

For initial requests: How will PRP serve to help this participant get to age appropriate development, more independent functioning and independent living skills?: _____

For concurrent requests: Has the youth made progress toward age appropriate development, more independent functioning and independent living skills? Y N

If yes, describe the improvement: _____

If no, describe changes to the treatment plan to address the lack of progress: _____
