Application for Psychiatric Rehabilitation Services

HUMANIM
HUMAN PURPOSE. HUMAN IMPACT.

Psychiatric Rehabilitation Services (including Day Program, Supported Living and Supported Employment services) are designed for adults and young adults with chronic and persistent mental illness to help them regain and maintain independence within the community. These services can include life skills teaching, intensive case management, in-home support, day program services, job placement and support services, and in some cases housing assistance. In addition, the Supported Living program can offer landlord mediation, financial management assistance and medication management.

This application must be completed in full and signed off on by a clinician.
To qualify for services, the individual must:

- have Medical Assistance.
- be in active treatment with provider prior to referral date (have met at least twice) and must remain in treatment while receiving Humanim services.
    - If only a single visit has occurred prior to referral date, please clearly explain the situation resulting in referral:
- have been experiencing functional impairments for at least 2 years prior to referral OR have a new onset Category A diagnosis.
- And, it has been determined that other types of services are not appropriate and PRP is needed.

Completed applications can be:

- emailed to BHAdmin@humanim.org, or
- faxed to Behavioral Health Admin at 410-381-5317,
- mailed to: Humanim, Behavioral Health Department, 6355 Woodside Court, Columbia, MD 21046.

Check all that apply:

☐ I am referring this person for Psychiatric Rehabilitation Day Services (day program)
☐ I am referring this person for Supported Living Services (in-home supports & case management)
☐Please check here if individual is between the ages of 18-26
☐ I am referring this person for Supported Employment Services

If you are referring for Supported Employment Services AND another service, please provide justification as to why both are needed:

Individual's Name: Last First Middle		
Individual's Address:		
Home #:	**Mobile #:**	**Email:**
Sex: ☐ Female ☐ Male		**Pronoun:**
Race: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Other:		
D.O.B:	**Age:**	**Social Security #:**
Medical Assistance #:		**MCO(if applicable):**
Sources of Income:		
Amount of Income:		

In order to qualify for services, the individual must meet one of the following DSM-5 diagnoses (Please check all that apply):							
Category A Diagnosis				Category B Diagnosis			
√	ICD-9	ICD-10	DSM 5 Diagnosis	√	ICD-9	ICD-10	DSM 5 Diagnosis
☐	295.90	F20.9	Schizophrenia	☐	296.33	F33.2	Major Depressive Disorder, Recurrent Episode, Severe
☐	295.40	F20.81	Schizophreniform Disorder	☐	296.43	F31.13	Bipolar I Disorder, Current or Most Recent Episode, Manic, Severe
☐	295.70	F25.0	Schizoaffective Disorder, Bipolar Type	☐	296.53	F31.4	Bipolar I Disorder, Current or Most Recent Episode, Depressed, Severe
☐	298.8	F28	Schizoaffective Disorder, Depressive Type	☐	296.40	F31.0	Bipolar I Disorder, Current or Most Recent Episode Hypomanic
☐	296.34	F33.3	Major Depressive Disorder, Recurrent Episode, w/Psychotic Features	☐	296.40	F31.9	Bipolar I Disorder, Current or Most Recent Episode Hypomanic, Unspecified
☐	296.44	F31.2	Bipolar I Disorder, Current or Most Recent Episode Manic, Severe, w/Psychotic Features	☐	296.7	F31.9	Bipolar I Disorder, Current or Most Recent Episode Unspecified
☐	296.54	F31.5	Bipolar I Disorder, Current or Most Recent Episode Depressed, Severe, w/Psychotic Features	☐	296.89	F31.81	Bipolar II Disorder
☐	298.9	F29	Other Specified Schizophrenia Spectrum and Other Psychotic Disorder	☐	301.83	F60.3	Borderline Personality Disorder
☐	297.1	F22	Unspecified Schizophrenia Spectrum and Other Psychotic Disorder	☐			
☐	297.1	F22	Delusional Disorder	☐			

The diagnostic criteria may be waived for either one of the following two conditions:	
☐	An individual found not competent to stand trial or not criminally responsible due to a mental disorder pursuant to Criminal Procedure, 3-101 et. seq. Annotated Code of Maryland, and receiving services recommended by a Behavioral Health Administration/Maryland Department of Health evaluator or facility or court order.
☐	An individual in a Maryland State psychiatric facility with a length of stay of more than 3 months who requires Residential Rehabilitation Program (RRP) services upon discharge. This excludes individuals eligible for Developmental Disabilities Administration Services.

The individual demonstrates impaired role functioning for at least two years. To be considered evidence of impaired role functioning at least three of the following must have been present on a continuing or intermittent basis	
☐	Marked inability to establish or maintain independent competitive employment.
☐	Marked inability to perform instrumental activities of daily living.
☐	Marked inability to establish or maintain a personal support system.
☐	Marked or frequent deficiencies of concentration, persistence, or pace.
☐	Marked inability to perform or maintain self-care.
☐	Marked deficiencies in self-direction.
☐	Marked inability to procure financial assistance to support community living.

Social Elements Impacting Diagnosis (Check all that apply)			
☐ None	☐ Access to Healthcare	☐ Housing Problems	☐ Social Environment
☐ Educational	☐ Legal System/Crime	☐ Occupational	☐ Homelessness
☐ Financial	☐ Primary Support	☐ Other Psychosocial / Environmental	☐ Unknown

If the individual has a co-occurring Substance Use Disorder (cannot be primary diagnosis), please indicate below							
Category A Diagnosis				**Category B Diagnosis**			
√	ICD-9	ICD-10	DSM 5 Diagnosis	√	ICD-9	ICD-10	DSM 5 Diagnosis
☐	305.00	F10.10	Alcohol Use Disorder – Mild	☐	304.20	FF14.20	Stimulant-Related Disorder – Cocaine – Severe
☐	303.90	F10.20	Alcohol Use Disorder – Moderate	☐	305.70	F15.10	Stimulant-Related Disorder – Amphetamine-type substance – Mild
☐	303.90	F10.20	Alcohol Use Disorder – Severe	☐	304.40	F15.20	Stimulant-Related Disorder – Amphetamine-type substance- Moderate
☐	305.20	F12.10	Cannabis Use Disorder – Mild	☐	304.40	F15.20	Stimulant-Related Disorder – Amphetamine-type substance – Severe
☐	304.30	F12.20	Cannabis Use Disorder – Moderate	☐	305.1	Z72.0	Tobacco Use Disorder – Mild
☐	304.60	F12.20	Cannabis Use Disorder – Severe	☐	305.1	F17.200	Tobacco Use Disorder – Moderate
☐	305.50	F11.10	Opioid Use Disorder – Mild	☐	305.1	F17.200	Tobacco Use Disorder – Severe
☐	304.00	F11.20	Opioid Use Disorder – Moderate	☐	305.90	F19.10	Other (or Unknown) Substance Use Disorder – Mild
☐	304.00	F11.20	Opioid Use Disorder – Severe	☐	304.90	F19.20	Other (or Unknown) Substance Use Disorder – Moderate
☐	305.60	F14.10	Stimulant-Related Disorder – Cocaine – Moderate	☐	304.90	F10.20	Other (or Unknown) Substance Use Disorder – Severe

Include any secondary Behavioral Health Diagnoses (if any):	

Include Medical Diagnoses (if any):	

Current Medications (if the primary diagnosis is a mood disorder, please list all medications used to treat this disorder, including dosage and frequency. If the individual is not taking medications, please provide an explanation as to why no medications are being taken.)	

Reason for Referral (check all that apply):			
Self-Care Skills:	☐ Personal Hygiene ☐ Grooming ☐ Nutrition	☐ Dietary Planning ☐ Food Preparation ☐ Self-Administration of Medicine	☐ Other:
Social Skills:	☐ Community integration activities ☐ Developing natural supports ☐ Developing linkages with, and supporting, the individual's participation in community activities ☐ Other:		
Independent Living Skills:	☐ Skills necessary for housing stability ☐ Community awareness ☐ Mobility and transportation skills ☐ Money management	☐ Accessing available entitlements and resources ☐ Health promotion and training ☐ Individual wellness self-management and recovery	☐ Other:
Other:			

If applying for Supported Employment Services:	
Previous Employment: Start Date: Employer: Wages: Job Description:	
Employment Barriers:	
☐ Communication ☐ Mobility and Transportation ☐ Money Management	☐ Clothing/resources needed for employment ☐ Assistance in Maintaining employment ☐ Criminal Background (Please explain):
Please indicate which of the following services have been offered or attempted prior to this referral for PRP services:	
☐ Targeted Case Management ☐ Individual and/or Group Therapy ☐ Peer support services ☐ Informal supports such as family	
If any of the above services have not been offered/attempted or if attempted but unsuccessful, please provide explanation:	
Please indicate why ongoing outpatient treatment is not sufficient to address concerns:	

Any additional information that you feel would be helpful in serving this individual:
Contact information of the person making referral: Name: Phone #:
Please indicate the referral source: ☐ Inpatient ☐ Residential Crisis ☐ Mobile/Assertive Community Treatment ☐ Mental Health Residential Treatment Center ☐ Incarceration ☐ Treating outpatient provider o Provider must be a licensed mental health provider who has assessed the individual as requiring the PRP level of care. The provider must be enrolled in Medicaid, either as an individual or through a licensed program that participates in Medicaid.
Provider Information (if applicable): Psychiatrist: Address: Phone: Therapist: Address: Phone: Primary Care: Address: Phone:

Referring Clinician's Name & Credentials (Print)
• Please note you must be a licensed mental health provider (Psychiatrist, CRNP-PMH, Licensed Psychologist, LCSW-C, LCPC, APRN-PMH, LCMFT, LCADC).
• LGPC, LMFT, LGADC, LGPAT – must be in a formal clinical supervision arrangement with a supervisor approved by the Maryland Board of Counselors and Therapists. Please provider supervisor's name:
• LMSW may only make referrals if currently in a formal clinical supervision arrangement with a supervisor approved by the Maryland Board of Social Work Examiners. Please provide supervisor's name:
• PA, RN-C, CAC-AD, CSC-AD – NOT eligible to make referrals.
• You must be enrolled in Medicaid, either as an individual or through a licensed program that participates in Medicaid.

Referring Clinician's Signature: Date:

Referring Clinician's Name & Credentials (print):

Agency Name (if applicable):

NPI # (of clinician or agency):