InnerSourced Solutions, Inc.

Adult Psychiatric Rehabilitation Program – Referral Form

This form must be completed in its entirety to allow for medical necessity determination and authorization of services.

Submit to: Referrals@InnerSourcedSolutions.com

DEMOGRAPHIC INFORMATION

Name: **Referral Date:**

Address:

Phone (primary): **Alternate:** **DOB:**

Medical Assistance #: **SS #:** **Gender:**

Race(s): **Marital Status:** **Veteran:** ☐ Yes ☐ No

Primary Language: **Education Level:**

Employment Status:

* InnerSourced Solutions, Inc. cur

GREY ZONE ELIGIBILITY (Required if no insurance)

If the individual has no insurance, at least one of the following criteria must apply:

- ☐ Homeless
- ☐ Receiving SSDI for a mental health reason
- ☐ Referred by order of a Conditional Release
- ☐ Received public mental health services within the past 2 years
- ☐ Discharged from a Maryland psychiatric hospital or residential crisis bed within the past 3 months
- ☐ Released from Dept. of Corrections/prison/jail within the past 3 months

DSM-5 / ICD-10 DIAGNOSIS

Eligibility for PRP services requires one of the following diagnoses (COMAR 10.63):

- ☐ **F20.9** Schizophrenia, Unspecified
- ☐ **F20.81** Schizophreniform Disorder
- ☐ **F20.0** Paranoid Schizophrenia
- ☐ **F20.1** Disorganized Schizophrenia
- ☐ **F20.2** Catatonic Schizophrenia
- ☐ **F20.3** Undifferentiated Schizophrenia
- ☐ **F20.5** Residual Schizophrenia
- ☐ **F20.89** Other Schizophrenia
- ☐ **F22** Delusional Disorder
- ☐ **F25.0** Schizoaffective Disorder, Bipolar Type
- ☐ **F25.1** Schizoaffective Disorder, Depressive Type
- ☐ **F25.8** Other Schizoaffective Disorders
- ☐ **F25.9** Schizoaffective Disorder, Unspecified
- ☐ **F28** Other Specified Schizophrenia Spectrum/Psychotic Disorder
- ☐ **F29** Unspecified Schizophrenia Spectrum/Psychotic Disorder
- ☐ **F21** Schizotypal Personality Disorder
- ☐ **F31.0** Bipolar I, Current Episode Hypomanic
- ☐ **F31.13** Bipolar I, Current Episode Manic, Severe
- ☐ **F31.2** Bipolar I, Current Episode Manic, With Psychotic Features
- ☐ **F31.4** Bipolar I, Current Episode Depressed, Severe
- ☐ **F31.5** Bipolar I, Current Episode Depressed, With Psychotic Features
- ☐ **F31.63** Bipolar I, Mixed, Severe, Without Psychotic Features
- ☐ **F31.64** Bipolar I, Mixed, Severe, With Psychotic Features
- ☐ **F31.81** Bipolar II Disorder
- ☐ **F31.9** Bipolar I Disorder, Unspecified
- ☐ **F33.2** Major Depressive Disorder, Recurrent, Severe
- ☐ **F33.3** Major Depressive Disorder, Recurrent, With Psychotic Features
- ☐ **F60.3** Borderline Personality Disorder

Additional DSM-5 Diagnosis: **Medical Diagnoses (ICD-10):**

MEDICATIONS (If Known)

Medication Name	Dosage / Frequency	Prescriber

PRIORITY POPULATION CRITERIA – ADULTS (COMAR 10.63)

Serious mental illness is characterized by impaired role functioning on a continuing or intermittent basis for at least two years. To meet priority population criteria, the individual must carry a qualifying diagnosis above AND meet at least three of the following functional limitations:

- ☐ Inability to maintain independent employment
- ☐ Social behavior that results in interventions by the mental health system
- ☐ Inability to procure financial assistance to support community living due to cognitive disorganization
- ☐ Severe inability to establish or maintain a personal support system
- ☐ Need for assistance with basic living skills

Note: The diagnostic criteria above may be waived for an individual committed as not criminally responsible who is conditionally released from a Mental Hygiene Administration facility, or an individual in an MHA facility with a stay exceeding 6 months who requires PRP services but does not carry a target diagnosis (excluding those eligible for Developmental Disabilities services).

Has the individual required intervention of the public mental health system within the past 2 years?

☐ Yes ☐ No

ADMISSION CRITERIA

All criteria below must be met for PRP admission:

1. The individual has a qualifying PMHS specialty mental health diagnosis and functional impairment expected to improve with PRP services.
2. The individual's mental illness has caused serious dysfunction in one or more life domains (home, school/work, community).
3. The dysfunction results in: a current threat to the individual's ability to remain in their customary setting; an emerging safety risk to self or others; or significant social impairment causing problems with relationships or family.
4. The individual is at risk of requiring a higher level of care, or is transitioning from a higher level of care.
5. The individual's condition requires an integrated program of rehabilitation services to restore independent living skills.
6. The individual does not require a more intensive level of care and is in sufficient behavioral control to safely benefit from PRP.
7. A documented crisis response plan is in progress or completed.
8. A current signed Individualized Treatment Plan is in progress or completed.
9. PRP services will be rendered by staff supervised by a licensed mental health professional.

CLINICAL JUSTIFICATION

Check the applicable clinical justification:

- ☐ Current outpatient treatment intensity is insufficient to reduce symptoms and functional impairment, prevent clinical deterioration, or avert the need for a more intensive level of care.
- ☐ The individual is transitioning from an inpatient, day hospital, or residential setting, and PRP services are necessary to support successful community transition or prevent the need for a more intensive level of care.

FUNCTIONAL ASSESSMENT

Assessment Measure: **Score:**

Inpatient psychiatric hospitalizations in past 6 months:

Legal involvement in past 6 months:

Summary of ITP Goals:

SOCIAL ELEMENTS IMPACTING DIAGNOSIS

Check all that apply:

- ☐ None
- ☐ Problems with access to healthcare
- ☐ Housing instability (non-homeless)
- ☐ Other psychosocial/environmental problems
- ☐ Educational problems
- ☐ Problems with primary support group
- ☐ Homelessness
- ☐ Unknown
- ☐ Financial problems
- ☐ Problems related to legal system
- ☐ Occupational problems

PRESENTING INFORMATION

Presenting Symptoms (include history of SI/HI and any judicial involvement):

RISK ASSESSMENT

Risk for aggressive behaviors, suicide, or homicide: ☐ N/A ☐ Yes – explain:

PSYCHIATRIC AND LEGAL HISTORY

History of inpatient psychiatric hospitalizations: ☐ Yes ☐ No

If yes, list facilities and dates (attach discharge summary if available):

History of court charges and/or incarcerations (check all that apply):

☐ Drug-related ☐ Theft ☐ Assault ☐ Weapons possession ☐ Sexual offense ☐ Other

Currently registered as a sex offender: ☐ Yes ☐ No **Number of arrests in past 90 days:**

ADDITIONAL CONTACTS

Primary Care Provider: **Phone:**

Psychiatrist: **Phone:**

Therapist/Counselor: **Phone:**

Case Manager: **Phone:**

Emergency Contact: **Phone:**

REQUIRED ATTACHMENTS

☐ Most recent discharge summary (if applicable)
☐ Most recent physical exam / history and physical
☐ Current medication list
☐ Current signed Individualized Treatment Plan

Individuals should bring to their first appointment: photo ID, Social Security card, birth certificate, proof of income, and health insurance card. If ID does not reflect a Maryland address, proof of Maryland residency (utility bill or lease) is required.

PATIENT AGREEMENT

I wish to be considered for services with InnerSourced Solutions, Inc.

Patient/Guardian Signature: **Date:**

REFERRING CLINICIAN ATTESTATION

By signing below, the referring clinician attests that the individual named herein is appropriate for Psychiatric Rehabilitation Program services. This referral must be signed by a treating psychiatrist, nurse practitioner, or independently licensed mental health practitioner. If the treating clinician holds an intermediate license, a Clinical Supervisor signature is also required below.

I, **, refer**

Treating Clinician – Signature & Credentials *Print Consumer's Name*

Clinician Name (print) & Credentials: **Phone:**

Clinician Email: **Date:**

Clinical Supervisor Signature (required if treating clinician holds an intermediate license):

Supervisor Signature & Credentials:

If applicable

Supervisor Name (print) & Credentials: **Date:**