EduCare Support Services, Inc.

Referral for Psychiatric Rehabilitation Program (PRP) & Behavioral Health Services
(OMHC / MTS / ASAM 3.1)

REFERRAL SOURCE INFORMATION

Date:
Name of Referring Provider / Credentials:
Agency Name:
Address:
City/State/Zip:

Mental Health / SUD Treatment Being Provided (Check all that apply):

☐ Outpatient Mental Health Services (OMHC)
☐ Substance Use Disorder Treatment
☐ Psychiatric Services / Medication Management
☐ Other: ____

CONSUMER INFORMATION

Full Name	
D.O.B:	**Age:**
Address:	
City/State/Zip:	
Phone:	**Email:**
Sex: ☐ Male ☐ Female ☐ Other **Service Location Requested:** ☐ Onsite ☐ Offsite ☐ Blended ☐ Residential (ASAM 3.1 – Rosewood House)	
Access to Transportation for Onsite Services: ☐ Yes ☐ No	

CLINICAL INFORMATION

(Do NOT ADD diagnosis unless authorized – for medical necessity review only) Behavioral Health Diagnoses (Check if applicable):

☐ F20.81 Schizophreniform Disorder
☐ F25.1 Schizoaffective Disorder, Depressive
☐ F25.0 Schizoaffective Disorder, Bipolar Type
☐ F29 Unspecified Psychotic Disorder
☐ F22 Delusional Disorder
☐ F33.2 Major Depressive Disorder, Severe
☐ F33.3 MDD with Psychotic Features
☐ F31.13 Bipolar I, Most Recent Manic, Severe
☐ F31.2 Bipolar I with Psychosis
☐ F31.5 Bipolar I, Depressed
☐ F31.8 Bipolar II Disorder
☐ F60.3 Borderline Personality Disorder
☐ F21 Schizotypal Personality Disorder
☐ F31.9 Unspecified Bipolar Disorder

DSM Diagnosis (if not listed): ______________________________

Primary Medical Diagnosis: ______________________________

SOCIAL DETERMINANTS / ENVIRONMENTAL FACTORS
(Check all that apply)

☐ None
☐ Access to Health Care
☐ Educational Barriers
☐ Legal System Involvement
☐ Primary Support Issues
☐ Housing Instability
☐ Homelessness
☐ Occupational Challenges
☐ Financial Hardship
☐ Social Environment Concerns
☐ Other: ______________________
☐ Unknown

Has the individual received Public Mental Health System services within the past 2 years?
☐ Yes ☐ No

FUNCTIONAL IMPAIRMENTS (Adults Only)
(At least 3 required for PRP eligibility)

☐ Inability to maintain employment
☐ Social behavior requiring intervention
☐ Cognitive disorganization impacting finances
☐ Limited or no social supports
☐ Needs assistance with basic living skills

CURRENT MEDICATIONS

____

____

____

____

Medication Compliance: ☐ Yes ☐ No

PRESENTING SYMPTOMS / HISTORY OF ILLNESS
(Include severity, duration, hospitalizations, ER visits, etc.)

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____

CRIMINAL HISTORY ☐ Yes ☐ No

REASON FOR REFERRAL
(Check all applicable service needs)

☐ Behavioral Issues
☐ Suicidal / Homicidal Ideation
☐ Emotional Regulation
☐ Executive Functioning
☐ Money Management
☐ Time Management
☐ Family Conflict
☐ Peer Conflict
☐ Housing Needs
☐ Transportation
☐ Emergency Room Visits
☐ Substance Use / Co-Occurring Disorders
☐ Medication Management
☐ Health & Wellness
☐ Hygiene
☐ Employment Support
☐ Community Resources
☐ Legal Support
☐ School Conflict
☐ Public Safety Concerns
☐ SSI/SSDI Assistances

REFERRAL AUTHORIZATION

Referring Provider Name & Credentials:	
Signature & Credentials:	**Date:**

EDUCARE USE ONLY

Staff Name: ____

Date Referral, Assertion of Need & Treatment Plan Received: __________________

Screening Scheduled within 5 Days: ☐ Yes ☐ No

COMPLIANCE STATEMENT
This referral form must be completed in its entirety to support medical necessity determination, authorization, and compliance with COMAR 10.63 regulations and Maryland Medicaid requirements.