Garrett County Lighthouse, Inc.
P.O. Box 116 Oakland, MD 21550
(301) 334-9126 Fax: (240)368-7564
Website: http://www.garrettcountylighthouse.org/

PHYSICIAN/MENTAL HEALTH PROFESSIONAL
PSYCHIATRIC REHABILITATION PROGRAM (PRP) SERVICES
YOUGHIOGHENY YOUTH CLUB ADOLESCENT PROGRAM
REFERRAL FOR PRP SERVICES

Youth's Full Name: _____
First Middle Last

Guardian's Name: _____
First Middle Last

Relationship to Youth: _____ Is this person the youth's legal guardian? ___Yes ___No

Guardian Telephone: (_____) _____-_____ (_____) _____-_____ (_____) _____-_____
Home Cell Other

Youth Telephone: (_____) _____-_____
Cell

Address: _____
Street City State Zip

DOB: _____/_____/_____ Age: _____ SS#: _____-_____-_____

Gender Identity:
☐ Male
☐ Female
☐ Choose Not to Disclose
☐ Did Not Ask Due to Child's Age or Other Reason
☐ Additional Gender Category or Other (*please specify*) _____
____Male-to-Female/Transgender Female/Trans Woman
____Female-to-Male/Transgender Male/Trans Man
____Genderqueer, Neither Exclusively Male or Female

Medical Assistance #: _____ MCO (*if known*): _____

Please provide the name and telephone number of a person we can contact in the event that there is difficulty reaching the parent/guardian of the person being referred for services.

_____ (_____) _____-_____ _____
Name Telephone Relationship

Do you have a relative that is currently employed by Garrett County Lighthouse, Inc.: ☐ yes ____ No

If yes, please provide person's name: _____

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Diagnosis: ICD-10 Code

Primary Diagnosis: _____ _____

_____ _____

_____ _____

Secondary Diagnosis: _____ _____

_____ _____

_____ _____

Medical Diagnosis: _____

Other Conditions that may be a Focus of Clinical Attention: _____

_____

Allergies: ____ Yes ____ No

If yes, please describe: _____

Eligibility:

Please verify that the person applying for services meets <u>ALL</u> of the following criteria by placing a check mark beside each criteria and by attaching clinical documentation for support (the list of required clinical documentation is listed below).

_____ The youth has a Public Behavioral Health System (PBHS) specialty mental health DSM-5 diagnosis and the youth's Impairment(s) and functional behavior can reasonably be expected to be improved or maintained by using these services.

_____ The youth's emotional disturbance is the cause of serious dysfunction in multiple life domains (Home, school, community).

_____ The impairment, because of the youth's emotional disturbance, results in:

- A clear, current threat to the youth's ability to be maintained in their customary setting, or
- An emerging/impending risk to the safety of the youth and others, or
- Other evidence of significant psychological or social impairments such as inappropriate social behavior causing serious problems with peer relationships and/or family members.

_____ The youth, due to the dysfunction, is at-risk for requiring a higher level of care, or is returning from a higher level of care.

_____ The youth's condition requires an integrated program of rehabilitation services to return to age appropriate development and to progress accordingly towards independent functioning and independent living skills

_____ The youth does not require a more intensive level of care and is deemed to be able to be safely maintained in the rehabilitation program and to benefit from the rehabilitation provider.

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_____ There is evidence that the use of pharmacotherapy, if deemed appropriate, has been considered by the primary clinician.

And either:

_____ There is clinical evidence that the current intensity of outpatient treatment is not sufficient to reduce the youth's symptoms and functional behavior impairment resulting from the mental impairment resulting from the mental illness and restore the youth to an appropriate functional level, or prevent clinical deterioration, or avert the need to initiate a more intensive level of care due to current risk to the youth or others.

Or alternatively:

_____ The youth is transitioning from an inpatient, day hospital or residential treatment setting to a community setting and there is clinical evidence that PRP services will be necessary to prevent clinical deterioration and support a successful transition back to the community or avert the need to initiate or continue a more intensive level of care.

Clinical Documentation: *(needed to request authorization for services)*

Required – Most Recent: *(check off attachments included)*

_____Psychiatric/Psychosocial Evaluations
_____Individual Treatment Plan
_____Progress Notes (2 to 3 months or most recent notes)

Also, if available: *(check off attachments included)*

_____ Discharge Plan (if person is leaving a hospital)
_____Current Physical Exam Results
_____Any other evaluations or information that help describe the person's status/needs.

Presenting Problem:

_____

_____

_____

_____

Medication Prescribed:

_____List Attached _____Written Below

_____

_____

_____

Substance Use Information:

Substance Use History *(include details of substance used (including alcohol), dates used, frequency, amount and how used (smoked, IV, etc.)*

_____

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_____

_____

Treatment History of Substance Use Disorders *(include detox, inpatient & outpatient services as well as dates of treatment)*

_____

_____

_____

Psychiatric Hospitalization:

Most Recent Psychiatric Admission: ____/____/____ Reason: _____

Total # of Psychiatric Admissions: _____Summary *(include hospital name & dates):* _____

_____

_____

_____

Legal Information:

_____

_____

_____

_____

Risk Assessment Information:

	Never	Past Week-Month	Past Month-Year	Past 2+ Years	Please Provide Specific Details
Suicide Attempts:					
Suicidal Ideations:					
Aggressive Behavior/Violence:					
Fire Setting/Arson:					

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Sexual Behavior(s) that are/were: nonconsensual, injurious, high-risk, forcible, pedophilia, etc.					
Self-Injurious/Mutilation (not suicidal)					

Referral Source: *Must be referred by a licensed Mental Health Professional. A "Licensed Health Professional" eligible to make referrals to a PRP is defined as a Psychiatrist, CRNP-PMH, Licensed Psychologist, LCSW-C, LCPC, APRN-PMH, LCMFT, LCADC, LCPAT, LGMFT, LGADC, or LGPAT. LGPC, LGMFT, LGADC, LGPAT and LMSW staff may only make referrals if they are currently in a formal clinical supervision arrangement with a supervisor approved by the Maryland Board of Professional Counselors and Therapists or the Maryland Board of Social Work Examiners, as applicable. (Supervisor's name, title and location must be provided). Referrals from non-mental health professionals who do not have a mental health specialty are not permitted. RN-C, CAC-AD, CSC-AD are not eligible to make referrals. The Licensed Mental Health Professional must be actively enrolled as a Medicaid Provider.*

_____ _____ (_____) _____-_____ _____
Name License/Credentials Telephone # Agency

_____ _____ (_____) _____-_____ _____
Supervisors Name (if applicable) License/Credentials Telephone # Agency

Signatures:

I understand that this application is being sent to determine if my child is eligible to obtain rehabilitation services from Garrett County Lighthouse, Inc. This application does not bind my child to receive services. I still have the right to change my mind later. I give Garrett County Lighthouse, Inc. permission to communicate with the referral source to discuss and share my child's medical and mental health history and information necessary for my child's referral.
This referral must be signed by the youth's parent/legal guardian.

Signature of Parent/Guardian: _____ Date_____

I recommend that this person receive rehabilitation services from Garrett County Lighthouse, Inc. (*must be referred by a licensed mental health professional. Please see the eligible list of eligible referral sources list above)*

Referral Source Signature: _____ Date: _____

Supervisor Signature (if applicable): _____ Date: _____

Completed referrals, along with all required attachments, can be submitted via fax or mail.
Please send to the attention to The Secretary of Adolescent Behavioral Health
Fax to (240) 368-7564 or Mail to Garrett County Lighthouse, Inc. P.O. Box 116, Oakland MD 21550

FOR INTERNAL USE ONLY

Receipt of Referral:
Agency received on: _____ Received By: _____ Screened by: ____ Date _____