Family Support Center of Maryland

Dear Fellow Professional,

Thank you for making a referral to Family Support Center of Maryland's (FSCMD) psychiatric rehabilitation program (PRP). The FSCMD psychiatric rehabilitation program provides support to individuals in developing community living and independent living skills while focusing on the individual's recovery and successful functioning. FSCMD provides a combination of services both onsite and offsite.

To Make a Referral to FSCMD:

1. Confirm that the person served is interested in Psychiatric Rehabilitation Program services.
2. **Complete the two-page referral form and the PRP Functional Criteria information page in accordance with the June 2023 changes to Optum's PRP authorization process.**
3. Provide copy of additional supporting documentation as a professional assertion of need for PRP services such as Treatment Plan, Clinical Assessment, etc (if applicable).
4. Fax or Email completed form and supporting documentation to Family Support Center of Maryland or the initial sender of Family Support Center of Maryland.
    a. Fax: 1-410-558-6254
    b. Email: info@familysupportcenterofmd.com

State-funded and uninsured participants must meet one of the following four eligibility criteria:

1. Stepdown from a state hospital and are on conditional release.
2. Discharge from an acute psychiatric hospitalization within the last six months.
3. Release from jail within the last six months.
4. Discharge from an RRP within the last six months.

When Family Support Center of Maryland receives initial referral forms, the person served will be contacted in order to schedule the intake appointment. In order to establish an maintain eligibility for FSCMD PRP services, individuals must remain under the care of a licensed mental health professional while in the program and must meet certain diagnostic criteria. A licensed mental health professional's signature is required on the referral form. In order to ensure continuity of care, an updated referral form for PRP concurrent authorization is required every six months

If additional information is needed, please contact FSCMD using the information below.

Family Support Center of Maryland, LLC
1927 Lansdowne Rd.
Halethorpe, MD 21227
(Office) 410-616-3508
(Gillian, Chief Operating Officer) 410-616-3507
(Elaine, Rehabilitation Specialist) 410-616-3503
(Efax) 1410-558-6254
(Email) info@familysupportcenterofmd.com

Thank you for your interest and trust in the Family Support Center of Maryland to serve the members of our vulnerable community.

Sincerely,

The Family Support Center Team

Date of Referral: _____

FAMILY SUPPORT CENTER OF MARYLAND
Referral Form for Psychiatric Rehabilitation Program (Adult-PRP)

DEMOGRAPHIC INFORMATION:

Consumer Name:		**Date of Birth:**	
Medical Assistance #:		**SSN:**	
Address: ☐ Homeless		**City, State, Zip:**	
Phone #:		**Race/Ethnicity:**	
Employed:	Yes ☐ No ☐ If No, seeking employment? _____	**Highest Level of Education Completed:**	
Veteran Status:	Non Veteran ☐ Veteran ☐	**Criminal History:**	Yes ☐ No ☐
Income Sources:	☐ Salary/Wages ☐ TCA/TDAP ☐ SSI ☐ SSDI ☐ Food Stamps ☐ Other _____		

Guardian Contact's Name (If Applicable):		**Relationship:**	
Phone #:		**Does Contact Person Have Legal Custody?**	☐ Yes ☐ No

BEHAVIORAL DIAGNOSIS & CLINICAL INFORMATION:

(Please indicate the participant's primary ICD-10 diagnosis from Category A or Category B below: (Choose only one.)

CATEGORY A

☐ F20.0 Paranoid Schizophrenia
☐ F20.1 Disorganized Schizophrenia
☐ F20.2 Catatonic Schizophrenia
☐ F20.3 Undifferentiated Schizophrenia
☐ F20.5 Residual Schizophrenia
☐ F20.81 Schizophreniform Disorder
☐ F20.89 Other Schizophrenia
☐ F20.9 Schizophrenia, Unspecified
☐ F25.0 Schizoaffective Disorder, Bipolar Type
☐ F25.1 Schizoaffective Disorder, Depressive Type
☐ F25.8 Other Schizoaffective Disorders
☐ F25.9 Schizoaffective Disorder, Unspecified
☐ F22 Delusional Disorder
☐ F28 Other Psychotic Disorder
☐ F29 Unspecified Psychosis
☐ F31.2 Bipolar I Disorder, Manic, Severe w/ Psychotic ft.
☐ F31.5 Bipolar I d/o, Depressed, Severe w/ Psychotic ft.
☐ F31.64 Bipolar I d/o, Mixed, Severe w/ Psychotic ft.
☐ F33.3 MDD, recurrent, severe w/ Psychotic ft.

CATEGORY B (If box is checked, answer questions below)

☐ F31.0 Bipolar I, Hypomanic
☐ F31.13 Bipolar I, Manic, Severe
☐ F31.4 Bipolar I, Depressed, Severe
☐ F31.63 Bipolar I d/o, Mixed, Severe w/o Psychotic
☐ F31.81 Bipolar II Disorder
☐ F31.9 Bipolar I, Unspecified
☐ F33.2 MDD, Recurrent Episode, Severe, w/o Psychotic ft.
☐ F60.3 Borderline Personality Disorder

Duration of current episode of treatment provided to this individual**
☐ Less than one month ☐ 7-12 months
☐ 2-3 months ☐ More than 12 months
☐ 4-6 months

Current frequency of treatment provided to this individual:**
☐ At least 1x/week ☐ At least 1x/3 months
☐ At least 1x/2 weeks ☐ At least 1x/6 months
☐ At least 1x/month

If an individual has a Category A diagnosis, they must meet one of the following:
C. Is the individual currently enrolled in SSI or SSDI? Yes ☐ No ☐
D. Demonstrates impaired role functioning for at least two years? Yes ☐ No ☐

Diagnosis given by: _____ Date: _____

Additional Behavioral Health Diagnosis: _____

FUNCTIONAL CRITERIA

Per medical necessity criteria, three or more of the following must have been present on a continuing or intermittent basis over the past two years. Please check the appropriate boxes.

Functional Impairment(s):

☐ Marked inability to establish or maintain competitive employment (pattern of unemployment or sporadic work history).
☐ Marked inability to perform instrumental activities of daily living (eg: shopping, meal preparation, laundry, basic housekeeping, medication management, transportation, and money management).
☐ Marked inability to establish/maintain a personal support system (social withdrawal/isolation, interpersonal conflict/social behavior).
☐ Marked or frequent deficiencies of concentration/ persistence/pace leading to failure to complete tasks.
☐ Marked inability to perform self-care (hygiene, grooming, nutrition, medical care, safety).
☐ Marked deficiencies in self-direction (inability to plan, initiate, organize and carry out goal directed activities).
☐ Marked inability to procure financial assistance to support community living.

Duration of Impairment(s):

Have marked functional impairment been present for at least two years? Yes ☐ No ☐ ;
If No, does the participant have a new onset (within past six months) Category A diagnosis? Yes ☐ No ☐

Primary Medical Diagnosis: _____

Social Elements Impacting Diagnosis: (Check all that apply)

☐ None	☐ Access to Health Care	☐ Housing Problems	☐ Social Environment
☐ Educational	☐ Legal System/Crime	☐ Occupational Challenges	☐ Homelessness
☐ Financial	☐ Primary Support	☐ Other Psychosocial/Enviro.	☐ Unknown

Current Psychotropic and Somatic Medications: (Please provide name and dosage amount**)**

Name - Dose – Directions	Name - Dose – Directions	Name - Dose – Directions

Is the individual med compliant: Yes ☐ No ☐

If the individual is not on medication, please explain why: _____

Severity of Illness and Presenting Symptoms (Please document the individual's history of presenting illness and current clinical state):

Current Treatment (If applicable): Please list the locations, dates, responsible parties and phone numbers of inpatient or outpatient settings in which the consumer currently participates. Please include current therapeutic services, as well.

1. _____

2. _____

Intensity of Services Necessary to Treat Illness (Please be concise and report justification for need of PRP services):

Will this person benefit from receiving Psychiatric Rehabilitation services? _____

Has group therapy been tried? Yes ☐ No ☐ If no, what is the reason this has not been tried? _____

_____

Has Targeted Case Management been tried? Yes ☐ No ☐ If no, what is the reason this has not been tried? _____

_____

Rehabilitation Services Needed:

(Indicate the areas you want the PRP to address.)

☐ Coping Skills	☐ Daily Living Activities	☐ Employment
☐ Social Skills/Peer Interaction	☐ Adult Vocational/Educational Skills	☐ Entitlements
☐ Self-Care	☐ Personal Support System	☐ Other _____

Referring Licensed Mental Health Practitioner:

Referring Agency / Facility:	NPI #:	
Email Address & Phone Number:		
Clinician (Name & Credentials):		
Signature & Credentials:		**Date:**

Supervisor Name & Credentials (if applicable):	

Attach a copy of the current Treatment Plan and Clinical Assessment.

PRP Staff: Date Referral and Assessment Received: _____

Coordinator Assigned: _____

PRP Functional Criteria

Individuals Name:

Date:

If the participant is not taking psychotropic medications to aid in treatment, provide explanation as to why?

Why is ongoing outpatient treatment not sufficient to address concerns?*

To understand what is being requested for each of the functional impairments below, a generalized example of a response is provided here:

1. Symptom of Priority Population diagnosis: Paranoia

2. Impairment impacting Functioning: Paranoia results in being suspicious of others.

3. Example of impaired function: Last week he would not get on the bus because he thought the driver was out to get him. He started yelling at the bus driver.

A. Does the participant have marked inability to establish or maintain competitive employment?*

1. Describe the symptoms of this Priority Population diagnosis that affect the participant's functioning*

2. Describe how, specifically, these symptoms impair the participant's functioning.*

3. Provide specific concrete examples of THIS participant's impaired function.*

B. Does the participant have marked inability to perform instrumental activities of daily living (e.g. shopping, meal preparation, laundry, basic housekeeping, medication management, transportation, and money management)?*

1. Describe the symptoms of this Priority Population diagnosis that affect the participant's functioning*

2. Describe how, specifically, these symptoms impair the participant's functioning.*

3. Provide specific concrete examples of THIS participant's impaired function.*

PRP Functional Criteria

C. Does the participant have marked inability to establish/maintain a personal support system?*

1. Describe the symptoms of this Priority Population diagnosis that affect the participant's functioning*

2. Describe how, specifically, these symptoms impair the participant's functioning.*

3. Provide specific concrete examples of THIS participant's impaired function.*

D. Does participant have deficiencies of concentration/persistence/pace leading to failure to complete tasks?*

1. Describe the symptoms of this Priority Population diagnosis that affect the participant's functioning*

2. Describe how, specifically, these symptoms impair the participant's functioning.*

3. Provide specific concrete examples of THIS participant's impaired function.*

E. Is the participant unable to perform self-care (hygiene, grooming, nutrition, medical care, safety)?*

1. Describe the symptoms of this Priority Population diagnosis that affect the participant's functioning*

2. Describe how, specifically, these symptoms impair the participant's functioning.*

3. Provide specific concrete examples of THIS participant's impaired function.*

PRP Functional Criteria

F. Does the participant have marked deficiencies in self-direction, shown by inability to plan, initiate, organize, and carry out goal directed activities?

1. Describe the symptoms of this Priority Population diagnosis that affect the participant's functioning*

2. Describe how, specifically, these symptoms impair the participant's functioning.*

3. Provide specific concrete examples of THIS participant's impaired function.*

G. Does the participant have marked inability to procure financial assistance to support community living?

1. Describe the symptoms of this Priority Population diagnosis that affect the participant's functioning*

2. Describe how, specifically, these symptoms impair the participant's functioning.*

3. Provide specific concrete examples of THIS participant's impaired function.*

Have peer supports and other informal supports such as family been tried?* ☐ Yes ☐ No

Explain why peer supports and other informal supports have not been sufficient.*

LMHP Signature: _____

Date:_____