lower shore clinic Go-Getters

208 E Main Street, Ste C
Salisbury, MD 21801
P: 410-341-3420x1 F: 410-651-4872
referral@lowershoreclinic.org

Referral for Psychiatric Rehabilitation Program and Vocational Services

- **Please fill out all the pages. Submit this form via fax to 410-651-4872 or email to referral@lowershoreclinic.org**
- All referrals must meet eligibility criteria in that they have a diagnosis approved by the ASO for authorization for PRP services. See attachment for list of approved diagnoses.
- Within 5 working days of receiving the completed referral the PRP will arrange for the applicant to visit to receive a face to face screening assessment to determine eligibility, rehabilitation, service needs, and willingness to participate. Also at this time, a determination will be made of the PRP's ability to address this individual's needs.
- Within 10 working days of the screening assessment, the individual will be notified whether the PRP: A. Accepts the individual; B. Will accept the individual following an updated review of the individual's eligibility, when the program capacity permits; C. Denies PRP services; D. Will accept the individual following an updated review of the individual's eligibility, after the individual's discharge or release from an inpatient facility or detention center.
- Within 10 working days of the PRP's acceptance of the individual, PRP staff will begin the enrollment process in accordance with the PRP regulations.
- Within 10 working days of the PRP's denial of the individual the PRP staff will notify the individual in writing according to the PRP regulations.

Services being referred for:
☐ **Day Program/ PRP** ☐ **Community Support PRP** ☐ **Vocational Program/Supported Employment**

Please answer the following as they are required for authorization to PRP services:

1. Education History; Highest level of education achieved: ____________________
2. Employment History: ____________________
   ____
3. Arrested or Incarcerated in last 30 Days? If yes, include charges: ____________________
   ____

Release/Authorization:
I, ____________________, authorize the release/exchange of all available information between the following agencies/individuals to support my application to Go Getters. This includes information that may pertain to denial or termination, including the reason for these actions, and when appropriate discharge plans. By my signature I understand and am agreeing to this Application for Rehabilitation Services. This release/authorization is effective for 90 days.
Emergency Contact: ____________________
Treatment Providers: Mental Health and Somatic: ____________________
Entitlement Agency: ____________________

Signature of Applicant: ____________________ Date: ____________________

____________________ ____________________
Referral Source Signature (Must be Mental Health Professional Include Credentials for PRP Referrals) Date

Applicant's Name: ____
(Last) (First) (MI)

Address: ____

Home Phone: ______________ Mobile Phone: ______________

Date of Birth: ______________ Social Security Number: ______________

Gender: ________ Gender Identity: __________ Race __________ Marital Status: ____________

Current Entitlements and Income: Fill in amounts and/or Insurance ID

SSI: ____________ SSDI: ____________ Other Income: ______________

Medicaid (MA): ______________ Medicare: ____________ Other Insurance: ______________

Referral Source Name: ______________________ Contact Number: ______________

Agency: ______________________ Phone Number: ______________

Mental Health Provider: ______________________ NPI: ______________

Referral Source Type: ☐ Inpatient/ Crisis Residential/ Residential Treatment Center/ Incarceration/ Assertive Community Treatment ☐ Outpatient Mental Health

Is the client actively enrolled in mental health treatment? ☐ Yes ☐ No

Has the provider met with the client at least two times? ☐ Yes ☐ No

Please indicate which service types the client has tried: ☐ Individual Therapy ☐ Group Therapy ☐ Targeted Case Management ☐ Peer Support Services ☐ Informal Supports- Such as family

If none, why not? ____

Primary Contact (Applicant, therapist, family, friend, other)- Name, phone number, and relationship

____

Current Psychiatric Diagnoses:	**ICD 10 Code**
Primary: ______________	______________
Secondary: ______________	______________
Tertiary/Additional: ______________	______________
______________	______________
Medical: ______________	______________
______________	______________

Psychiatric Hospitalizations: Number of Psychiatric Hospitalizations (Lifetime) ______________

Dates, Locations, Length of Stay: ____

____

____

Primary Care Provider: Name & Contact Information: ______________________________

Significant Somatic Issues: ____

____

All Current Medications: Prescriptions, Over the Counter, and Supplements. Please include full list

Name/Dosage/Frequency/Prescriber

____

____

____

____

Currently Able to take medications: Independently ☐ With Reminders ☐ With Daily Supervision ☐

Refuses Medication: ☐ No Medications Currently Prescribed ☐

Comments: ____

____

Functional Impairments: Please comment on the areas below, provide specific examples, evidence, or symptoms for each:

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

   ☐ Yes ☐ No

   ____

   ____

2. Does the participant have marked inability to perform instrumental activities of daily living, like shopping, meal preparation, laundry, housekeeping, medication management, transportation, or money management?

   ☐ Yes ☐ No

   ____

   ____

3. Does the participant have marked inability to establish/maintain a personal support system? Who is in the current support system?

   ☐ Yes ☐ No

   ____

   ____

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

   ☐ Yes ☐ No

   ____

   ____

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

   ☐ Yes ☐ No

   ____

   ____

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

   ☐ Yes ☐ No

   ____

   ____

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

   ☐ Yes ☐ No

   ____

   ____

8. Has the client ever been enrolled in Targeted Case Management:

   ☐ Yes ☐ No

   ____

   ____

9. Does the client participate in Peer Support Services (AA/NA, Group Therapy, Peer Supports, IOP, other):

   ☐ Yes ☐ No

   ____

   ____

Other evidence of marked impairment that prevent successful community living:

____
____
____
____
____

Legal History/Forensic Involvement

History of Arrest: Yes ☐ No☐ On Probation or Parole ☐ Yes ☐ No

Parole/Probation Officer & Phone: ____

List Any Reported Convictions: ____

____

Has applicant ever been found NCR? Yes ☐ No ☐ Currently or Planned for Conditional Release ☐ Yes ☐ No

Substance Use/Abuse History:

Current Substance Use: Period of Use, Frequency/Cost, Route: ____________________________

____

Historical Substance Use: Dates of Last Use, Amount, Route: ____________________________

____

Substance Use Treatment History: Include dates and Locations

Support and Recovery Programs: ____

Formal Detox: ____

Inpatient Services: ____

Outpatient Services: ____

Risk Assessment: (Frequency, date of last incident, severity of incident)

Suicide Attempt: ____

Suicidal Ideation: ____

Self-Harm: ____

Aggressive Behavior/Violence: ____

Homicidal Ideation: ____

Fire-Setting: ____

Activities of Daily Living: Completes Independently: ☐ Needs Significant Support ☐ Needs Moderate Support ☐

Current Daily Activities: Recreation/Leisure/Social: ______________________________

____

Previous PRP/RRP Involvement? Yes ☐ No ☐ If Yes, Locations/Programs/ Reasons for Termination:

____
____

Consumer Provider Preference: ____

Cultural Preference of Consumer: ____

Specific ways that program services are expected to help this individual: ____________________

____
____
____

Is Consumer in Agreement with PRP Referral? ☐ Yes ☐ No If No, Please Explain: ____________________

____