

**CROSSROADS COMMUNITY, INC.
REFERRAL FORM**

Services:

- Adult PRP (18yo +)
- Healthy Transitions – TAY Care
Coordination (aged 16 – 25yo)
- Youth PRP (up to 17yo)
- Supported Employment (VOC) (16 yo+)
- Overnight Respite (4 to 17yo)

****Residential** - clients needing RRP, must submit Application For Residential Rehabilitation Services to Mid-Shore Behavioral Health (contact # 410-770-4801)

Send All Referrals to:

Program Director
Crossroads Community, Inc.
120 Banjo Lane
Centreville, MD 21617

Phone: 410-758-3050 ext. 1030
Fax: 410-758-1223

CLIENT INFORMATION

Please check if this is a self-referral and complete as much information as possible.

Name _____ DOB _____ Gender: M F Other:

Address _____

Town _____ County _____ State _____ Zip Code _____

Phone # _____ Cell Phone # _____ Work Phone # _____

Email: _____

MEDICAL ASSISTANCE# _____ **SOCIAL SECURITY#** _____

LEGAL GUARDIAN No Yes- Name: _____

Phone # _____ Cell Phone # _____ Work Phone # _____

EMERGENCY CONTACT (*Two contacts are required for Minors*)

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

CURRENT LIVING SITUATION: Independent W/Parent/Guardian/Family member

Homeless/Shelter Other (*explain*): _____

MARITAL STATUS: Single Married Divorced Widowed Separated

VETERAN No Yes - which war are they a veteran of? _____

RACE: Black/African American White American Indian/Alaskan Native

Native Hawaiian/Other Pacific Islander Asian Not Available

ETHNICITY: Hispanic/Latino Yes No

FINANCIAL INFORMATION: No Income

Supplemental Security Income (SSI) Amount _____

Social Security Disability Insurance (SSDI) Amount _____

Other Source(s): _____ Amount _____

Employed Wages _____ Position/Employer: _____

EDUCATION: In School? Yes No Highest Grade Completed: _____

PRIMARY HEALTH CARE PROVIDER

Name _____ Phone _____

THERAPIST (or treating clinician): Agency _____

Name _____ Phone _____

Email: _____

OTHER AGENCY INVOLVEMENT? DDA DSS DJS Probation Substance Use PRP

Please Specify Provider(s): _____

Complete applicable section based on services being referred:

PRP/VOC: Adults (18yo+) please complete the following

ADULTS MUST HAVE ONE OF THE FOLLOWING DIAGNOSIS FOR PRP/VOC ELIGIBILITY

F 20.0 Paranoid Schizophrenia	F 31.0 Bipolar I Disorder, Current or Most Recent Episode Hypomanic
F 20.1 Disorganized Schizophrenia	F 31.13 Bipolar I Disorder, Current or Most Recent Episode Manic, Severe
F 20.2 Catatonic Schizophrenia	F 31.2 Bipolar I D/O, Current or Most Recent Episode Manic Psychotic Features
F 20.3 Undifferentiated Schizophrenia	F 31.4 Bipolar I Disorder, Current or Most Recent Episode Depressed, Severe
F 20.5 Residual Schizophrenia	F 31.5 Bipolar I D/O, Most Recent Episode Depressed, w/ Psychotic Features
F 20.81 Schizophreniform Disorder	F 31.63 Bipolar I Disorder, Mixed, Severe, w/o Psychotic Features
F 20.89 Other Schizophrenia	F 31.64 Bipolar I Disorder, Mixed, Severe, w/ Psychotic Features
F 20.9 Schizophrenia, unspecified	F 31.81 Bipolar II Disorder
F 22 Delusional Disorder	F 31.9 Bipolar I Disorder, Unspecified
F 25.0 Schizoaffective Disorder, Bipolar Type	F 33.2 Major Depressive Disorder, Recurrent Episode, Severe
F 25.1 Schizoaffective Disorder, Depressive Type	F 33.3 Major Depressive Disorder, Recurrent Episode, W/ Psychotic Features
F 25.8 Other Schizoaffective Disorders	F 60.3 Borderline Personality Disorder
F 25.9 Schizoaffective Disorder, unspecified	
F 28 Other Specified Schizophrenia Spectrum and Other Psychotic Disorder	
F 29 Unspecified Schizophrenia Spectrum and Other Psychotic Disorder	

A. Diagnosis: please indicate current primary behavioral diagnoses. F code: _____

B. Please complete only if applicable. Diagnostic criteria may be waived for the following conditions:

An individual on Conditions of Release (COR) without a priority dx. F code: _____

A TAY (18-25yo) individual who does not have a priority dx listed above. F code: _____

C. The impairment results in at least three of the following continual or intermittently for at least 2 years:

- Marked inability to establish or maintain independent competitive employment
- Marked inability to perform instrumental activities of daily living
- Marked inability to establish or maintain a personal support system
- Marked or frequent deficiencies of concentration, persistence or pace leading to failure to complete tasks
- Marked inability to perform or maintain self-care
- Marked deficiencies in self-direction, characterized by an inability to independently plan, initiate, organize, and carry out goal-directed activities
- Marked inability to procure financial assistance to support community living.

PRP/VOC/RESPITE: Children and Adolescents (Aged 17 and Under) - please complete the following

To be eligible the youth must have 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.

A. Diagnosis of a serious emotional disorder. F code(s): _____

B. The youth's mental illness is the cause of serious dysfunction in one or more life domains (please check)
 Home School Community

C. The impairment results in **at least one** of the following:

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

D. In addition each of the following are true. The youth:

- Due to dysfunction, is at risk for requiring a higher level of care, or is returning from a higher level of care.
- Requires an integrated program of rehabilitation services to return to age appropriate development and to progress accordingly towards independent functioning and independent living skills,
- Does not require a more intensive level of care and is judged to be in enough behavioral control to be safe in the rehabilitation program and benefit from the services provided.

HEALTHY TRANSITIONS – TAY Care Coordination: Young Adults Aged 16 – 25 yo

A. Diagnosis. F code(s): _____

B. If not in mental health therapy, is this client agreeable to being linked? Yes No

FOR ALL REFERRALS:

Additional Diagnoses: F codes: _____

Are you the diagnosing clinician? Yes

If not, then who was the diagnosis given by (name & credentials): _____

Please Attach Copies Of The Following:

- Current Psychosocial, Psychiatric or Psychological Evaluation
- Current Clinical Treatment Plan

MEDICATIONS: NONE (Please include additional sheet if needed)

Type	Dosage/Frequency	Prescribed By:

HOSPITALIZATION OR PLACEMENT HISTORY (Include at least the last 6 months) NONE

Dates _____ Hospital/Program _____

Dates _____ Hospital/Program _____

Dates _____ Hospital/Program _____

Is the consumer deaf, or do they have serious difficulty hearing? Yes No Unknown

Is the consumer blind have serious difficulty seeing, even when wearing glasses? Yes No Unknown

Because of a physical, mental or emotional condition, does the consumer have serious difficulty concentrating, remembering or making decisions? Yes No Unknown

Does the consumer have serious difficulty walking or climbing stairs? Yes No Unknown

Does the consumer have serious difficulty dressing or bathing? Yes No Unknown

Because of a physical, mental or emotional condition, does the consumer have difficulty doing errands alone such as visiting a doctor's office or shopping? Yes No Unknown

SERVICES NEEDED:

- | | | |
|---|---|---|
| <input type="checkbox"/> Activities of Daily Living | <input type="checkbox"/> Safety to Self/Others | <input type="checkbox"/> Vocational Skills/Employment |
| <input type="checkbox"/> Anger/Temper/Conflict Resolution | <input type="checkbox"/> School Performance | <input type="checkbox"/> Leisure Skills |
| <input type="checkbox"/> Assertiveness/Self-esteem | <input type="checkbox"/> Sexual Issues | <input type="checkbox"/> Work/Job Performance |
| <input type="checkbox"/> Community Activity/Resources | <input type="checkbox"/> Social Skills/Peer Interaction | <input type="checkbox"/> Money Management |
| <input type="checkbox"/> Family/Natural Supports | <input type="checkbox"/> Substance Use | <input type="checkbox"/> Nutrition/Eating Disorder |
| <input type="checkbox"/> Finances/Entitlements | <input type="checkbox"/> Coping Skills | <input type="checkbox"/> Crisis Management Skills |
| <input type="checkbox"/> Home/Housing | <input type="checkbox"/> Trauma/Abuse/Assault | <input type="checkbox"/> Physical Health/Medical Providers |
| <input type="checkbox"/> Self-Care Skills | <input type="checkbox"/> Medication Compliance Skills | <input type="checkbox"/> Legal Issues (# of arrests in last 30 days _____) |
| <input type="checkbox"/> Psychological/Therapy | <input type="checkbox"/> Public Transportation | |

Explain the need for services:

REFERRAL SOURCE:

Name _____ Agency _____
Address _____ Phone _____
Email: _____

Collaboration Agreement: I understand the need for and agree to work collaboratively with CCI staff for the purpose of treatment planning. Yes No

REFERRAL AGREEMENT

I agree with this referral and authorize the Referral Source to release/exchange information to Crossroads Community, Inc. (CCI) for the purpose of facilitating the disposition of the referral. If this referral is not from my treating clinician then I authorize the exchange of information between CCI and my treating clinician for the purpose of facilitating the disposition of the referral. I understand that the information exchanged may include the diagnosis, evaluations and records of progress. I understand that this authorization is valid for one year from the date of signing, and that I may retract it in writing at any time.

Signed _____ **Date** _____

Parent/Guardian _____ **Date** _____

[REQUIRED FOR PROCESSING For PRP & Respite Services Only**]**

I certify that this individual's condition requires an integrated program of rehabilitation services to develop and restore independent living skills to support the individual's recovery.

Print Name of Referring Psychiatrist/Therapist _____ **Date** _____

Signature & Credentials _____

** Must be signed by an approved licensed level clinician (Psychiatrist, CRNP-PMH, Licensed Psychologist, LCSW-C, LCPC, APRN-PMH, LCMFT, LCADC). Optum requires Interns and Master Levels to have supervisor sign off.