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 DIAGOSIS 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:

Are medications being used to manage the symptoms of behavioral health conditions, if not have they been considered and why not?

_____

_____

_____

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:

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

Explain the need for services:

_____

_____

_____

_____

_____

Symptoms and Impact on functioning (should support the impairments listed above):

_____

_____

_____

_____

Detail the duration and frequency of therapy sessions:

_____

_____

_____

Provide evidence of why less-intensive services (targeted case management/Group Therapy/Peer Support Services/Informal Supports) and outpatient therapy alone has not been sufficient:

_____

_____

_____

REFERRAL SOURCE:

Name_____ Agency _____

Address_____ Phone _____

NPI #: _____ 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.