CROSSROADS COMMUNITY, INC.
REFERRAL FORM

Services:

☐ Adult PRP

☐ Young Adult PRP (16 – 25yo)

☐ Youth PRP

☐ Supported Employment (VOC) (16 yo+)

☐ Overnight Respite

☐ Targeted Case Management for Adults (TCM)

****Residential -** clients needing RRP, please submit Application For Residential Rehabilitation Services to Mid-Shore Behavioral Health (contact # 410-770-4801)
** **PATH** (homeless outreach is a separate referral form please see website www.ccinconline.com or call 410-490-3139)

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 #_____

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*): _____
Hurricane Victim? ☐Yes ☐No ☐ Unknown

MARITAL STATUS: ☐Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
VETERAN ☐No ☐ Yes - which was 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_____

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 20.9 Schizophrenia (all types)	F 31.13 Bipolar I Disorder, Current or Most Recent Episode Manic, Severe
F 20.81 Schizophreniform Disorder	F 31.2 Bipolar I D/O, Current or Most Recent Episode Manic Psychotic Features
F 25.0 Schizoaffective Disorder, Bipolar Type	F 31.4 Bipolar I Disorder, Current or Most Recent Episode Depressed, Severe
F 25.1 Schizoaffective Disorder, Depressive Type	F 31.5 Bipolar I D/O, Most Recent Episode Depressed, w/ Psychotic Features
F 28 Other Specified Schizophrenia Spectrum and Other Psychotic Disorder	F 31.0 Bipolar I Disorder, Current or Most Recent Episode Hypomanic
F 29 Unspecified Schizophrenia Spectrum and Other Psychotic Disorder	F 31.9 Bipolar I D/O, Current or Most Recent Episode Hypomanic, Unspecified
F 22 Delusional Disorder	F 31.9 Bipolar I Disorder, Current or Most Recent Episode Unspecified
F 33.2 Major Depressive Disorder, Recurrent Episode, Severe	F 31.9 Unspecified Bipolar and Related Disorder
F 33.3 Major Depressive Disorder, Recurrent Episode, W/ Psychotic Features	F 31.81 Bipolar II Disorder
F 21 Schizotypal Personality Disorder	F 60.3 Borderline Personality Disorder

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

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

1. An individual on Conditions of Release (COR) without a priority dx. F code: _____
2. **Transitional Aged Youth** (an individual 18-25yo with a Child & Adolescent dx). F code: _____

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

☐ A clear, current threat to the individual's ability to manage current living situation
☐ Inability to be employed or attend school without support
☐ Inability to manage the effects of his/her mental illness

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

BHA includes for the C &A priority population all psychiatric disorders listed in DSM-V or ICD-10 **with the exception of** "V" codes, substance use, and developmental disorders, which are excluded unless they co-exist with another diagnosed psychiatric disorder. All of these disorders have episodic, recurrent, or persistent features; however, they vary in terms of severity and disabling effects

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 the youth:

☐ Due to dysfunction, is at risk for requiring a higher level of care, or is returning from a higher level of care.
☐ 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.

TCM: Adults (18yo+) - please complete the following:

Individuals must be in a federal eligibility category for Maryland Medical Assistance Program according to COMAR 10.09.24, and have a serious and persistent mental health disorder.

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

B. Please check appropriate eligibility criteria:

☐ Are at risk of, in need of continued community treatment to prevent, or are being discharged from inpatient psychiatric treatment;

☐ Are at risk of, or need continued community treatment to prevent being homeless

☐ Are at risk of incarceration or will be released from a detention center or prison

C. Level of Case Management Services Requested

General: Based on the severity of the participant's mental illness, and the participant meets **at least one** of the following conditions:

- ☐ Not linked to mental health and medical services
- ☐ Lacks basic supports for shelter, food, and income;
- ☐ Transitioning from one level of care to another level of care
- ☐ Needs to maintain community-based treatment and services
- ☐ Shelter Plus Care (Uninsured Only)

Intensive: Intensive: Based on the severity of the participant's mental illness, and the participant urgently meets **more than one** of the following conditions:

- ☐ Not linked to mental health and medical services
- ☐ Lacks basic supports for shelter, food, and income
- ☐ Transitioning from one level of care to another level of care
- ☐ Needs to maintain community-based treatment and services

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_____

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 or LINKAGES 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:

_____

_____

_____

_____

_____

_____

REFERRAL SOURCE:

Name_____Agency _____

Address_____ Phone _____

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 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 _____