

THE Southern Maryland Community
NETWORK
Champions of Behavioral Health

CALVERT COUNTY

305 Prince Frederick Blvd.
Prince Frederick, MD 20678
(410) 535-4787 Office
(410) 535-4965 Fax

ST. MARY'S COUNTY

41900 Fenwick Street, Suite 5
Leonardtown, MD 20659
(301) 475-9315 Office
(301) 475-9317 Fax

CHARLES COUNTY

2670 Crain Highway, Suite 505
Waldorf, MD 20601
(301) 932-9146 Office
(301) 932-9361 Fax

IHIP PROGRAM

PRP for Minors

1915i Waiver

Demographic Information

Referral Date: _____

Child's Name: _____ **Date of Birth:** _____ **Age:** _____

SS#: _____ **Sex:** _____ **Race:** _____

Address: _____ **City** _____ **State** _____ **Zip** _____

County of Residence: _____ **Phone Number:** _____

Parent/Guardians Name: _____

Address (if Different from Child): _____

City _____ **State** _____ **Zip** _____

Home phone: _____ **Work Phone:** _____

Marital status: **Married** **Single** **Divorced** **Widowed**
 Living with significant other **Living with relative** **Foster Family**

Other (Please describe) _____

Names and ages of all household members: _____

Spirituality: _____

Insurance Information

Medical Assistance Number: _____

M.A. Managed Care Company: _____

Referral Source

****Minor must be in active mental health treatment with a licensed professional to be served by PRP services.****

Name of referring Person: _____ Credentials/Title: _____

Address: _____ City _____ State _____ Zip _____

Phone: _____ Organization: _____

Signature of Licensed Mental Health Professional including credentials/title: _____

Therapist agrees the minor's life skills can be expected to improve through medically necessary Rehabilitation services. Yes No

Court Ordered (If yes, note Court and Contact Name): Yes No

Reason for Referral: _____

This minor is judged to be in enough behavioral control to be safe in PRP:
 Yes No

What places the child at risk of being placed out of the home at this time? _____

Has this referral been reviewed/discussed with the consumer's parent/guardian?
 Yes No

Signature of Parent/Guardian: _____

Education

Child's School: _____ **Grade:** _____

Special Education Needs: _____

School Psychologist: _____ **Phone:** _____

Clinical Information

Outpatient Therapist: _____ **Phone:** _____

Please check the outpatient therapist's credentials below:

LGSW LCSW LCSW-C LGPC LCPC PhD PsyD

Address: _____

Outpatient Psychiatrist: _____ **Phone:** _____

Address: _____

DSM V diagnosis code: _____

Current Medication (dosage and time): _____

Previous Hospitalizations/ RTC/ Out of Home Placements (Include Location and dates):

Presenting Problems (Please circle all that apply as well as frequency)

Anger Management
Mild Moderate Severe
Frequency _____

Sibling Conflict
Mild Moderate Severe
Frequency _____

Parent/child conflict
Mild Moderate Severe
Frequency _____

Conflict resolution
Mild Moderate Severe
Frequency _____

Peer conflict
Mild Moderate Severe
Frequency _____

Suicidal ideation
Mild Moderate Severe
Frequency _____

School refusal
Mild Moderate Severe
Frequency _____

Medication compliance
Mild Moderate Severe
Frequency _____

Suicide attempts
Mild Moderate Severe
Frequency _____

Poor daily routines
Mild Moderate Severe
Frequency _____

Poor social Skills
Mild Moderate Severe
Frequency _____

Homicidal ideation
Mild Moderate Severe
Frequency _____

Poor hygiene
Mild Moderate Severe
Frequency _____

Neighborhood safety
Mild Moderate Severe
Frequency _____

Homicidal attempts
Mild Moderate Severe
Frequency _____

Running away
Mild Moderate Severe
Frequency _____

Breaking Curfew
Mild Moderate Severe
Frequency _____

Physical aggression
Mild Moderate Severe
Frequency _____

Sexualized behaviors
Mild Moderate Severe
Frequency _____

Drug use
Mild Moderate Severe
Frequency _____

Verbal aggression
Mild Moderate Severe
Frequency _____

Sexual abuse Suspected
Mild Moderate Severe
Explain _____

Physical abuse suspected
Mild Moderate Severe
Frequency _____

DSS involvement
Mild Moderate Severe
Frequency _____

Sexual abuse confirmed
Mild Moderate Severe
Explain _____

Physical abuse confirmed
Mild Moderate Severe
Frequency _____

Impulsive
Mild Moderate Severe
Frequency _____

Parent/ family loss
Mild Moderate Severe
Frequency _____

Property destruction
Mild Moderate Severe
Frequency _____

Stealing
Mild Moderate Severe
Frequency _____

Self-Injurious
Mild Moderate Severe
Frequency _____

Abuse of pets
Mild Moderate Severe
Frequency _____

Injury to others
Mild Moderate Severe
Frequency _____

Fighting
Mild Moderate Severe

Firearms in the home
Mild Moderate Severe

Fire settings
Mild Moderate Severe

Please attach the following documentation to assist us in processing this referral:

- _____ Psychiatric Evaluation _____ Release of Information
 _____ Letter of recommendation for IHIP services

Please review to make sure you have completed **ALL** sections of this referral. A member of the IHIP-C or PRP team will be in contact with the referral source and family upon review. If you have further questions or concerns, please contact the Program Coordinator:

IHIP-C – Calvert County: Program Coordinator, 410-535-4787 ext. 333

PRP – Calvert County: Program Coordinator, 410-535-4784 ext. 318

IHIP-C & PRP – St. Mary’s County: Program Coordinator, 301-475-9315 ext. 11

IHIP-C & PRP – Charles County: Program Coordinator, 301-932-9146 ext. 105

Fax the completed referral form with attached documentation to:

CALVERT COUNTY	CHARLES COUNTY	ST. MARY’S COUNTY
Local Behavioral Health Authority 1020 N Prince Frederick Blvd., Suite 300 P.O. Box 980 Prince Frederick, MD 20678 (443) 295-8584 ext. 104 Fax (443) 968-8979	Local Behavioral Health Authority 10480 Theodore Green Blvd. P.O. Box 1050 White Plains, MD 20695 (301) 609-5753 Fax (301) 609-5749	Local Behavioral Health Authority 21580 Peabody Street P.O. Box 316 Leonardtown, MD 20650 (301) 475-4330 Fax (301) 363-0312