Referral For Community Service Programs

Fax Attention: Morgan Wyman
St. Mary's County: (240) 309-4160
Charles County: (240) 419-3201
Encrypted Email: mwyman@pathwaysinc.org
Morgan Wyman cell: 240-309-8242

Please be sure to answer all parts of the application or N/A when appropriate.

This application will not be considered complete without the following:

_____ Psychiatric Evaluation (supporting diagnosis documents)
_____ Psychological Assessment (if applicable)
_____ Discharge Summary (if applicable)
_____ Conditional Release (if applicable)
_____ Licensed Mental Health Professional's Signature **(required)**

RECOMMENDED SERVICES:

Community Support _____ (Charles & St. Mary's Counties) On-Site Support (Day Program) _____ (St. Mary's County) IHIP-A _____** (Calvert, Charles & St. Mary's Counties)

I. DEMOGRAPHICS

Name:_____ SSN: _____
DOB: _____ Sex: _____ Phone: _____
Address: _____
_____
Applicant lives with:
_____Spouse _____Child _____Parent(s) _____Alone Other _____
Marital Status: _____ Children & Ages: _____
Last completed grade/ level of education: _____ Occupation: _____

II. FISCAL INFORMATION

Does applicant have:	Yes	No	Pending		
Medical Assistance	___	___	____	Number_____	Exp_____
Medicare	___	___	____	Number_____	Exp_____
SSDI/SSI	___	___	____	Amount $_____	
Earned Income	___	___	Average Monthly Income $_____		
Food Stamps	___	___	Amount $_____		
Insurance	___	___	Type_____	Company_____	
Other	___	___	Amount $_____		
Rep Payee	___	___	Name _____		
			Phone _____		

III. REFERRAL INFORMATION

Person Making Referral _____ Phone _____
Email address:_____ Other Contact number _____
Name & Address of Agency _____
Therapist _____ Phone_____
Case Manager_____ Phone_____
Medical Primary _____ Phone_____
Psychiatrist _____ Phone_____

IV. PSYCHIATRIC HISTORY

Current Diagnosis ICD Code: ___.___ Secondary: ___.___ Date of Assessment: _____

Reason for Referral: _____

_____

Describe applicant's current situation: _____

_____

Applicant's goals/objectives: _____

_____

_____

Applicant's past hospitalizations and dates, begin with the most recent: _____

_____

_____

Outpatient treatment and dates: _____

_____

_____

Is the applicant currently suicidal? _____ Does the applicant have a history of suicidal ideation and/or behavior? _____ Please describe: _____

_____

Does the applicant currently display assaultive/aggressive behavior? _____

Is there a history of assaultive/aggressive behavior? _____ If Yes, please describe: _____

_____

What other information may be helpful in crisis prevention and stabilization for applicant: _____

_____

_____

_____

V. MEDICAL HISTORY

List past or current medical conditions/diseases of applicant and treatment: _____

_____

_____

_____

Does applicant have any:	Yes	No	
Allergies	____	____	To: _____
Special Dietary Considerations	____	____	Type: _____
Medical Handicaps/Disabilities	____	____	Type: _____
Neurologic Disorder	____	____	Type: _____
Communicable Disease	____	____	Type: _____

VI. MEDICATIONS

Please list current (a) medications, (b) dosages, and (c) frequency to include date of any last injection:

(a)	(b)	(c)

VII. SUBSTANCE ABUSE HISTORY

Does the applicant have a history of substance abuse? _____ If Yes, indicate substance(s) and treatment:

_____

_____

Is there a current known substance abuse? _____ If Yes, indicate substance(s), frequency of use and last known use:_____
_____
_____

Is applicant on an antabuse or any other prescribed medication in conjunction with substance abuse treatment? _____ If Yes, indicate medication, dosage and frequency: _____
_____

What other information may be helpful in relapse prevention? _____
_____
_____
_____

VIII. LEGAL HISTORY

Does applicant have any current and/or pending charges? _____ If Yes, list charges and court dates: _____
_____
_____

Attorney: _____ Phone: _____

Prior legal charges, dates, states and dispositions (if known): _____
_____

Signature of person completing the application:

_____ _____
Signature **Date**

_____ _____
Title ***License**

***All Psychiatric Rehabilitation Program referrals require a licensed mental health professional's signature.**

Eligibility Requirements

1. Consumer ***must meet eligibility necessity criteria*** and have a current **target diagnosis** listed below. **Chose from the following and include documentation**:

Diagnosis	ICD-9 CODE	ICD-10 CODE	Mark as Primary or secondary
Schizophrenia	295.90	F20.9	
Schizophreniform Disorder	295.40	F20.81	
Schizoaffective Disorder– Bipolar Type	295.70	F25.0	
Schizoaffective Disorder– Depressive Type	295.70	F25.1	
Other Specified Schizophrenia Spectrum and Other Psychotic Disorder	298.8	F28	
Unspecified Schizophrenia Spectrum and Other Psychotic Disorder	298.9	F29	
Delusional Disorder	297.1	F22	
Major Depressive Disorder-Recurrent Episode–Severe	296.33	F33.2	
Major Depressive Disorder-Recurrent Episode–With Psychotic Features	296.34	F33.3	
Bipolar I Disorder Current or Most Recent Episode Manic–Severe	296.43	F31.13	
Bipolar I Disorder Current or Most Recent Episode Manic–With Psychotic Features	296.44	F31.2	
Bipolar I Disorder Current or Most Recent Episode Depressed–Severe	296.53	F31.4	
Bipolar I Disorder Current or Most Recent Episode Depressed–With Psychotic Features	296.54	F31.5	
Bipolar I Disorder Current or Most Recent Episode Hypomanic	296.40	F31.0	
Bipolar I Disorder Current or Most Recent Episode Hypomanic–Unspecified	296.40	F31.9	
Bipolar I Disorder – Current or Most Recent Episode, Unspecified	296.7	F31.9	
Unspecified Bipolar and Related Disorder	296.80	F31.9	
Bipolar II Disorder	296.89	F31.81	
Borderline Personality Disorder	301.83	F60.3	

2. If available, please provide a copy of the most recent **psychological evaluation**, or documentation recording diagnosis criteria list above.

3. Consumers must have some form of **federal/state funded insurance** that is currently active (i.e. Medical Assistance and EID)

Please feel free to contact me with any questions:

Morgan Wyman
Community Services Outreach Specialist
240-309-8242 (cell)
mwyman@pathwaysinc.org

CONSENT TO RELEASE INFORMATION

I give my consent to _____ (mental health or somatic health care provider) to release any medically necessary information to Pathways, Inc. I understand that the information may be shared with the _____ CSA (IHIP-A only) to release this application and other clinical and psycho-social history to the Community Services Program in order to assess my eligibility for services in the community. I additionally give my consent to Pathways to share statistical information with the county Core Service Agency to enable the authority to monitor the use of services they help to fund.

I understand that this information will not be released to any other party without my express written consent.

I understand that I may revoke this consent at any time by a written statement. This consent is valid for 12 months from the date of my signature.

_____ _____

Signature of Applicant **Date**

_____

Signature of Witness

****In Home Intervention Program for Adults (IHIP-A) Requires LBHA Approval.**
Referrals for IHIP-A Service can be faxed to the Local Behavioral Health Authority in the county in which the consumer resides.

Calvert County LBHA (443) 295-8584 ext. 103 Fax: (443) 968-8979
Attn: Wayne Millette
Charles County LBHA (301) 609-5750 Fax: (301) 609-5749
Attn: Karen Black
St. Mary's County LBHA (301) 475-4324 Fax: (301) 475-9434
Attn: Jaime Barnes