**\*\*\*PLEASE INCLUDE ASSESSMENT/EVALUATION WITH FORM\*\*\***

**Please fax to 410 779 9400 or email to fccc1@hushmail.com**

| **Consumer Name:** | **D.O.B:** | |
| --- | --- | --- |
| **Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Does the Parent/Guardian have legal custody (if minor)? \_\_Yes \_\_No** | | |
| **Address:** | | |
| **City:** | **State:** | **Zip:** |
| **Home Phone:** | **Cell #** | |
| **Medical Assistance/Medicaid #:** | | |
| **Is the individual currently receiving SSI/SSDI \_\_Yes\_\_No** | | |
| **Is the individual eligible for full funding for Developmental Disabilities Administration services**  **\_\_Yes \_\_No** | | |
| **Is the primary reason for the impairment due to an organic process of syndrome, intellectual disability, a neurodevelopmental disorder or neurocognitive disorder ? \_\_Yes \_\_No** | | |
| **Has the individual been found not competent to stand trial or not criminally responsible and is receiving services recommended by a Maryland Dept of Health Evaluator ? \_\_Yes \_\_No** | | |
| **Clinical Information** | | |
| **Is the participant receiving outpatient mental health services? \_\_Yes\_\_No** | | |
| **Is the licensed mental health provider enrolled as a provider in the Medicaid program? \_\_Yes\_\_No** | | |
| **Is the participant on medication? \_\_Yes\_\_No** | | |
| **If selected, are the medications prescribed for MDD (Major Depressive Disorder) or Bipolar?**  **Medication Name:** | | |
| **Why is ongoing outpatient treatment not sufficient to address concerns?** | | |
| **Occupational** | | |
| **Is the participant employed?\_\_Yes\_\_No**  **Has the participant been referred to supported employment? \_\_Yes\_\_No\_\_N/A** | | |

| **ICD-10 Primary Diagnosis Code** |  |
| --- | --- |
| **Diagnosing Clinician and Title** |  |
| **Duration of current episode of treatment provided to this individual**  Two or more visits in the last three months | |
| **Current frequency of treatment provided to this individual**  At least 1x/week | |

| **Functional Criteria (Check all that apply and comment where checked)** |
| --- |
| **To understand what is being requested for each of the functional impairments below, a generalized example of a response is provided here:**  1. Symptom of Priority Population diagnosis**: Paranoia**  2. Impairment impacting Functioning**: Paranoia results in being suspicious of others.**  3. Example of impaired function: **Last week he would not get on the bus because he thought the driver was out to get him. He started yelling at the bus driver.** |

|  | **Marked inability to establish or maintain competitive employment:** |
| --- | --- |
| **Provide evidence of marked inability to establish or maintain competitive employment:**    **1) Describe the symptoms of this Priority Population diagnosis that affect the participant's functioning:**    **2) Describe how, specifically, these symptoms impair the participant's functioning:**    **3) Provide specific concrete examples of THIS participant's impaired function.:** | |

|  | **Marked inability to perform instrumental activities of daily living (e.g: shopping, meal preparation, laundry, basic housekeeping, medication management, transportation and money management)** |
| --- | --- |
| **Provide evidence of marked inability to establish or maintain competitive employment:**    **1) Describe the symptoms of this Priority Population diagnosis that affect the participant's functioning:**      **2) Describe how, specifically, these symptoms impair the participant's functioning:**  **3) Provide specific concrete examples of THIS participant's impaired function.:** | |

|  | **Marked inability to maintain personal support system** |
| --- | --- |
| **Provide evidence of marked inability to establish or maintain competitive employment:**    **1) Describe the symptoms of this Priority Population diagnosis that affect the participant's functioning:**      **2) Describe how, specifically, these symptoms impair the participant's functioning:**  **3) Provide specific concrete examples of THIS participant's impaired function.:** | |

|  | **Deficiencies of concentration/persistence/pace leading to failure to complete tasks** |
| --- | --- |
| **Provide evidence of marked inability to establish or maintain competitive employment:**    **1) Describe the symptoms of this Priority Population diagnosis that affect the participant's functioning:**      **2) Describe how, specifically, these symptoms impair the participant's functioning:**  **3) Provide specific concrete examples of THIS participant's impaired function.:** | |

|  | **Unable to perform self-care (hygiene, grooming, nutrition, medical care, safety)** |
| --- | --- |
| **Provide evidence of marked inability to establish or maintain competitive employment:**  **1) Describe the symptoms of this Priority Population diagnosis that affect the participant's functioning:**      **2) Describe how, specifically, these symptoms impair the participant's functioning:**  **3) Provide specific concrete examples of THIS participant's impaired function.:** | |

|  | **Marked deficiencies in self direction, shown by inability to plan, initiate, organize and carry out goal directed activities.** |
| --- | --- |
| **Provide evidence of marked inability to establish or maintain competitive employment:**    **1) Describe the symptoms of this Priority Population diagnosis that affect the participant's functioning:**      **2) Describe how, specifically, these symptoms impair the participant's functioning:**    **3) Provide specific concrete examples of THIS participant's impaired function.:** | |

|  | **Marked inability to procure financial assistance to support community living** |
| --- | --- |
| **Provide evidence of marked inability to establish or maintain competitive employment:**    **1) Describe the symptoms of this Priority Population diagnosis that affect the participant's functioning:**      **2) Describe how, specifically, these symptoms impair the participant's functioning:**  **3) Provide specific concrete examples of THIS participant's impaired function.:** | |

| **Duration of impairments (check off all that applies)** | |
| --- | --- |
| 𝥷 Marked functional impairment has been present for less than 2 years | 𝥷 Marked functional impairment has been limited to less than 3 of the above listed areas |
| 𝥷 Has demonstrated marked impairment functioning primary due to a mental illness in at least three of the areas listed above at least 2 years | 𝥷 Has demonstrated impaired role functioning primarily due to a mental illness for at least 3 years |

| Has consideration been given to using peer support and other informal support such as family? \_\_Yes\_\_No |
| --- |
| List attempts and outcomes of any efforts to serve this individual through less formal means such as peer supports, or family: |
| Has the participant been judged to be in enough behavioral control to be safe in a rehab program and benefit from the rehab provided?: |
| List specific ways in which PRP services are expected to help this individual: |

**Licensed Provider Completing this Application:**

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_

Supervisor Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_