K&I Healthcare Services
Maryland's Leading Providers for Outpatient Mental Health & Recovery

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Psychiatric Rehabilitation Program (PRP) Referral

The Maryland Behavioral Health Administration requires a referral by a licensed mental health professional every six months for initiation and continuation of PRP services. This document permits mental health professionals to submit the requirement in a single document.

Client Name:_____ Date of Birth: _____ SSN:_____
Street Address: _____
City/State/Zip: _____ Phone: _____
Medicaid #:_____ Email: _____
Is the client aware of this referral?___ Primary Language: _____
Gender:_____ Orientation:_____ Pronouns: _____

Primary ICD-10 Diagnosis Code:_____ Additional ICD-10 Diagnosis Code:_____
Additional ICD-10 Diagnosis Code:_____ Additional ICD-10 Diagnosis Code:_____
Medical Diagnosis Code:_____

Referring Agency Name:_____
Provider Name/Credentials:_____ NPI#_____
Provider Phone:_____ Provider email:_____

The above-named individual is being referred to receive Psychiatric Rehabilitation Integrated Services from K & I Healthcare Services. My signature below is verification that the client, based on my assessment, does not require a more intensive level of care, and is deemed to be able to maintain and benefit from the services to be provided.

This service is deemed necessary to improve the individuals quality of life and healthy living practices by creating a sense of belonging consisting of more independence with little to no need for intensive mental health and paid supports promoting long-term recovery and resilience using harm reduction models of care to reduce inpatient hospitalization, assist clients with a clearer understanding of illness management as well as facilitate wellness and recovery and reduce drug related charges, offenses, deaths and illnesses. ***Below is detailed information to identify symptoms/impairments/dysfunction with specific examples experienced by the individual.***

__ Inability to procure financial assistance to support community living and/or establish or maintain employment (pattern of unemployment, underemployment, or sporadic work history) as evidenced by:___
_____

__ Inability to perform instrumental activities of daily living or complete tasks commonly found in the home, work, school environment to include the ability to maintain self-care and personal safety (deficiencies of concentration, persistence or pace, failure to complete task in a timely manner) as

evidenced by:_____

_____

__ Inability to establish or maintain personal relationships, improve social, emotional and communication skills, conflict resolution through anger management, increase self-esteem (social withdrawal or isolation, interpersonal conflict, or social behavior, other than criminal that is not easily tolerated by the community) as evidenced by:_____

_____

__ Unproductive behavior to include deficiencies in self-direction and inability to perform or maintain self-care (inability to independently plan, initiate, organize and carry out goal directed activities which affects areas of hygiene, grooming, nutrition, medical and personal safety) as evidenced by:_____

_____

A Documented Crisis/Safety response plan is (check one): __ In progress __completed __N/A
Pharmacotherapy (if deemed appropriate) has been considered by the primary treating clinician.
Check one: __Yes __No __Not applicable
If yes, please list medication name dosage and frequency:
Medication:_____ Dosage:_____ Frequency:_____
Medication:_____ Dosage:_____ Frequency:_____
Medication:_____ Dosage:_____ Frequency:_____

COVID Vaccination Status: OBJ__Fully __Partially __Not Vaccinated
Recent Hospitalization/ER Visit: OBJ__Yes __No If yes, Date:_____
Recent Discharge from Jail/Psych Hospital/RRP: __Yes __No If yes, Date:_____
Documents Attached: __Psych Eval __Psych Assmt __SSA Verification __Discharge Sum
Is there a History of Violence/Aggression? OBJ____ History of Substance Abuse? ___

Additional Clinical Rationale:_____

_____

My signature below indicates I am a mental health professional enrolled in Maryland Medicaid either directly or through a program enrollment. I am not affiliated with the Psychiatric Rehabilitation Program and I am actively providing services to the above named individual and agree to work collaboratively with K&I Healthcare Services for PRP Services.

_____ _____

Signature and Title/Licensure of Mental Health Professional Date:

_____ _____

Clinician Name Printed:

_____

Masters or Graduate Level Supervisor Name/ Credentials (if applicable)