LIFTING STIGMAS
CHANGING LIVES
OUTPATIENT MENTAL HEALTH CLINIC • COMMUNITY OUTREACH ORGANIZATION

Please fax to 410-665-2632 or email to referrals@lscl.org

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 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		

ICD-10 Primary Diagnosis Code	
Diagnosing Clinician and Title	
Duration of current episode of treatment provided to this individual □Less than one month □ One visit in the last three months □ Two or more visits in the last three months	
Current frequency of treatment provided to this individual □At least 1x/week □ At least 1x/2 weeks □At least 1x/month □ At least 1x/3months □ At least 1x/6months	
Has the individual received PRP services from at least one other PRP within the past year? □ Yes □ No	

REFERRAL SOURCE

Agency Name:	Therapist Name& Credentials
Address:	
Phone #:	Fax #:
Email Address:	

Criteria for admission (CHECK ALL THAT APPLY AND COMMENT WHERE CHECKED)	
□	**Marked inability to establish or maintain competitive employment**
Provide evidence of marked inability to establish or maintain competitive employment.	

☐	**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 perform instrumental activities of daily living (e.g: shopping, meal preparation, laundry, basic housekeeping, medication management, transportation and money management).

☐	**Marked inability to maintain personal support system**

Provide evidence of marked inability to establish/maintain a personal support system.

☐	**Deficiencies of concentration/persistence/pace leading to failure to complete tasks**

Evidence of deficiencies of concentration/persistence/pace leading to failure to complete tasks.

☐	**Unable to perform self-care (hygiene, grooming, nutrition, medical care, safety)**

Evidence of inability to perform self-care (hygiene, grooming, nutrition, medical care, safety.

☐	**Marked deficiencies in self direction, shown by inability to plan, initiate, organize and carry out goal directed activities.**

Evidence of marked deficiencies in self direction, shown by inability to plan, initiate, organize and carry out goal directed. activities.

☐	**Marked inability to procure financial assistance to support community living**

Evidence of marked inability to procure financial assistance to support community living.

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

Licensed Provider Completing this Application:

Print Name: _ _____ Signature_____ Date_____

Lifting Stigmas and Changing Lives
8409 Harford Road, Parkville MD 21234
(P) 410-656-3906 (F) 410-665-2632