**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** |

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| **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: |

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| **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\_\_\_\_\_\_\_\_\_\_\_\_\_