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

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| --- | --- |
| **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 eligible for full funding for Developmental Disabilities Administration services?****𐄂 Yes 𐄂 No** |
| **Have family or peer supports been successful in supporting this youth? 𐄂 Yes 𐄂 No** |
| **Is the primary reason for the youth’s impairment due to an organic process of syndrome, intellectual disability, a neurodevelopmental disorder or neurocognitive disorder 𐄂 Yes 𐄂 No** |

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| --- | --- |
| **ICD-10 Primary Diagnosis Code** |  |
| **Diagnosing Clinician and Title** |  |
| **Clinician Agency**  |  |
| **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 |
| **How long has youth been engaged in active, documented outpatient treatment?**𐄂Less than one month 𐄂 One visit in the last three months 𐄂 Two or more visits in the last three months |
| **Is the youth transitioning from an inpatient, day hospital or residential setting to the community setting?** 𐄂 Yes 𐄂 No |
| **Does the youth have a Target Case Management referral or authorization?** 𐄂 Yes 𐄂 No |
| **Has medication been considered for this youth?**𐄂 Not considered 𐄂 Considered and Ruled Out 𐄂 Initiated and Withdrawn 𐄂 Ongoing 𐄂 Other Comments: |

**REFERRAL SOURCE**

|  |  |
| --- | --- |
| Agency Name: | Contact Person Name: |
| Address: |
| Phone #: | Fax #: |
| Email Address: |

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| **Criteria for admission (CHECK ALL THAT APPLY AND COMMENT WHERE CHECKED)** |
|  | **A clear, current threat to the individual’s ability to be maintained in his/her customary setting** |
| **Provide of evidence of clear, current threat to the youth’s ability to be maintained in their customary setting:** |
|  | **An emerging/pending risk to the safety of the individual or others** |
| **Provide evidence of emerging risk to the safety of the youth or others:** |
|  | **Significant psychological or social impairments such as inappropriate social behaviors causing serious problems with peer relationships and/or family members** |
| **Provide evidence of significant psychological or social impairments causing serious problems with peer relationships and/or family members:** |
| **What evidence exists to show that the current intensity of outpatient treatment for this individual is insufficient to reduce the youth’s symptoms and functional behavioral impairments:** |
| **How will PRP serve to help this youth get to age appropriate development, more independent functioning and independent living skills:** |

**Licensed Provider Completing this Application**:

Print Name: \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_