Client Name:	ID #:

Referral Information

Referral Date:	Intake Interview Date:	Date Written Referral Is received by Licenced Professional

Referral Source (*Name, Credentials, Org)*	Referral Phone: ext:
	Staff Conducting Interview Credentials Title

Reason for Referral / Presenting Problems

Client currently receiving the following services from the referring licensed mental health professional.
(Check all that apply)

- ☐ Inpatient:
- ☐ Residential Treatment Center
- ☐ Outpatient Mental Health Services
- ☐ Signed/Dated Referral (or ITP) Received from Licensed Mental Health Professional

Health Insurance Information

☐ Medical Assistance ☐ Medicare ☐ Private | Number:

EVS Verification: ◯ Yes ◯ No ◯ Info Unavailable

- ☐ Beacon Health (BHA) documentation for Uninsured Eligibility Benefit Form:
- ☐ BHA Uninsured Eligibility Registration Form: ☐ N/A
- ☐ Verification of Uninsured Eligibility Status: ☐ N/A

Comments	Comment (include info regarding managed care)

☐ Check Here if No Other Conflicting Services

List Conflicting PRP Services Below (Per Medicaid)

Client currently receiving other PRP services: ☐ Yes ☐ No ☐ Uncertain	If Yes Specify:
Client currently receiving Mobile Treatment Services: ☐ Yes ☐ No ☐ Uncertain	If Yes Specify:
Client currently receiving Case Management Services: ☐ Yes ☐ No ☐ Uncertain	If Yes Specify:

Client Name:	ID #:

Client Identifying and Contact Information

Client Identification Information

Client ID#	Client Name: *First, Last, Middle*	Email:	
Phone:	Address: *Street Address City State Zip*	Date of Birth	Age:
Primary language of Client:	☐ Check if there are other languages spoken in the home	If yes, what language(s):	

Racial or Ethnic Group (check all that apply)

☐ Caucasian	☐ Middle Eastern-American	☐ Asian
☐ Mexican-American (Hispanic)	☐ Central American (Hispanic)	☐ Middle Eastern
☐ Cuban-American	☐ South American (Hispanic)	☐ African
☐ Native-American	☐ Caribbean (African)	☐ Indian
☐ African-American	☐ Caribbean (Hispanic)	☐ Eastern European
☐ Asian-American	☐ Pacific Islander	☐ Other:

Gender:

◯ Male
◯ Female
◯ Transgender,

Explain:

Marital Status

(Check One)

◯ Single ◯ Married ◯ Married, Living Apart ◯ Life Partner ◯ Divorced ◯ Widowed ◯ Other:

Emergency Contact Information

(List up to two emergency contacts. If client has a legal guardian enter him/her as First Contact and CHECK BOX)

First Contact ☐ Legal Guardian	Name:	Relationship to Client:	Address:	
	Email:	Home Phone	Work Phone	Cell
Second Contact	Name:	Relationship to Client:	Address:	
	Email:	Home Phone	Work Phone	Cell

Current Life Situation

(Check all questions that are affirmative)

What are your current living arrangements:

☐ Group Home	☐ Halfway House/Residential Treatment Program	☐ Unknown
☐ Private Residence	☐ Psychiatric Hospital /other institution	☐ Other:
☐ Outdoors	☐ Jail /Correctional Facility	
☐ LongTerm Shelter	☐ Hotel, SRO, Boarding House	
☐ Short Term Shelter	☐ Apt, Room or House -Own or Other persons'	

Client Name: ID #:

Current Life Situation Continued

(Check all questions that are affirmative)

Military Veteran: ◯ Yes ◯ No

Comment:

Highest Grade Completed in School:

If Homeless, Specify Length of Time ◯ Unknown ◯ 2-30 Days ◯ 91-days to 1 year ◯ Not Homeless ◯ Less than 2 Days ◯ 31-90 Days ◯ Over 1 year

Comments:

Referral Name, Title

Organization

Phone | Email

Reason For Referral

Income /Entitlements / Other

☐ Check if Unknown

Check all that apply and the amount:

☐ SSI	☐ SSDI	☐ Rental Assistance	☐ Food Stamps
☐ WIC	☐ TEMHA	☐ Wages	

☐ Other: Specify:

☐ Additional Income: Specify:

Current Day Activity / Employment Site

◯ None, skip section ◯ Has daily activity, continue below

Position: | Address:

Superviser/Contact: | Phone:

Comments:

Legal Involvement

(Check all that apply):

☐ None, denies history (if none, proceed to next page)

☐ History of Criminal / Legal

What charges, year and outcome:

☐ Current Legal / Criminal Involvement

What charges, outcome?

☐ Present legal involvement, probation or parole

◯ Probation ◯ Parole

Officer Name:

Phone: Email:

Conditions of probation or parole:

Client Name:	ID #:

Medical and Behavioral Health History

☐ Check box if not applicable

Name and credentials of Coordinator of Services

Name:	Licensure/Credentials:	Date:

Primary Physician	Address	Phone

Within the past 30 days, have you experienced any of the following symptoms?

- ☐ I have not experienced any of the symptoms listed below
- ☐ Convulsions Unconsciousness
- ☐ Hallucinations, delusions
- ☐ Unusual and/or heavy bleeding
- ☐ Severe bruises
- ☐ Untreated fractures
- ☐ Disorientation to time, place, person
- ☐ Persistent pain
- ☐ Severe headache with blurred vision
- ☐ Recent head injury
- ☐ Vision Problems
- ☐ Hearing Problems

Comments:

☐ Do you have any allergies (food, medications, chemicals, vapors, etc.)? Please list allergies:

☐ Are you currently involved in any behaviors that risk compromising your safety and/or health? (Examples: Unprotected sex, needle sharing, criminal behavior, excessive use of drugs and/or alcohol, etc.) If yes, explain:

Risk/Danger to Self and Others

(Check all that apply at admission to the program or revision date)

Describe Risk/Danger Below

SUICIDAL BEHAVIOR:	☐ DENIES	☐ HISTORY	☐ CURRENT
AGGRESSIVENESS:	☐ DENIES	☐ HISTORY	☐ CURRENT
SUBSTANCE ABUSE:	☐ DENIES	☐ HISTORY	☐ CURRENT
SEXUAL ABUSE:	☐ DENIES	☐ HISTORY	☐ CURRENT
PHYSICAL ABUSE:	☐ DENIES	☐ HISTORY	☐ CURRENT

PSYCHIATRIC HOSPITALIZATION OR SPECIAL BEHAVIORAL UNIT:

☐ NOT IN PAST 2 Years ☐ HISTORY ☐ CURRENT

Comments:

Client Name:	ID #:

MEDICAL INFORMATION

(List significant medical problems including seizure disorders)

☐ Check box if client has no medical concerns at this time

Medical Diagnosis/Health Concern & Date of Onset	Treating Medical Professional / Phone	Treatment (List Prescribed Medications Chart below)
	Name Phone	
	Name Phone	
	Name Phone	
	Name Phone	
	Name Phone	
	Name Phone	

☐ Check box for Not Applicable

Current Medications *(prescribed and non-prescribed):*

Name	For What	Who prescribed	When prescribed	Strength	Dosage	Side Effects	Benefits	Compliance *(Check box)*
								☐
								☐
								☐
								☐
								☐
								☐
								☐
								☐
								☐
								☐

Client Name:	ID #:

☐ Check box for Not Applicable

Current Medications *(prescribed and non-prescribed):*

Name	For What	Who prescribed	When prescribed	Strength	Dosage	Side Effects	Benefits	Compliance *(Check box)*
								☐
								☐
								☐
								☐
								☐

Diagnoses and Admitting Criteria

DSM-5 Diagnoses	ICD-9 and ICD-10 Diagnoses Codes

Comments on Patient History:

Client Name:	ID #:

ADMISSION CRITERIA

****ALL 10 of the following criteria are necessary for admission to PRP****

I have Reviewed the Following Admission Criteria: ☐ **Yes** ☐ **No**

1. The participant has a PBHS specialty mental health DSM 5 diagnosis and the participant's impairment(s) and functional behavior can reasonably be expected to be improved or maintained by using these services.
2. The participant's mental illness is the cause of serious dysfunction in one or more life domains (home, school, community)
3. The impairment results in at least ONE of the following:
   a. A clear, current threat to the participant's ability to live in his/her customary setting.
   b. An emerging/pending risk to the safety of the participant and others.
   c. Other evidence of significant psychological or social impairments, such as inappropriate social behavior, causing serious problems with peer relationships and/or family members.
4. The participant, due to the dysfunction, is at-risk for requiring a higher level of care or is returning from a higher level of care.
5. The participant's condition requires an integrated program of rehabilitation services to develop and restore independent living skills to support the participant's recovery.
6. The participant does not require a more intensive level of care and is judged to be in enough behavioral control to be safe in the rehabilitation program and benefit from the rehabilitation provided.
7. A documented crisis response plan for the participant is in progress or completed.
8. An individual rehabilitation plan (IRP) is in progress or completed.
9. PRP services will be rendered by staff that are supervised by a licensed mental health professional
10. And either:
    a. There is clinical evidence that the current intensity of outpatient treatment will not be sufficient to reduce the participant's symptoms and functional behavioral impairment resulting from the mental illness and restore him/her to an appropriate functional level, or prevent clinical deterioration, or avert the need to initiate a more intensive level of care due to current risk to the participant or others.
    b. For participant *transitioning from an inpatient, day hospital or residential treatment setting to a community setting* there is clinical evidence that PRP services will be necessary to prevent clinical deterioration and support successful transition back to the community, or avert the need to initiate or continue a more intensive level of care.

Client Name:	ID #:

SEVERITY OF NEED AND INTENSITY OF SERVICE

I have reviewed the Following Severity of Need and Intensity of Service Criteria for PRP services: ☐ **NO** ☐ **YES**

(Checking Yes indicates that Client's severity of need and intensity of service are suitable for BHLD PRP)

Medical necessity for admission to PRP services must be documented by the presence of ALL of the following criteria:

1. The length and frequency of the services varies based on the participant's needs and medical necessity.
2. Professional and/or social supports must be identified and available to the participant outside of program hours and the participant or the participant's parent/caretaker must be capable of seeking them as needed.
3. The participant's parent / caretaker must be capable of seeking supports as needed.
4. Active involvement of the participant, family, caretakers, or significant others involved in the participant's treatment will be sought.

Additional Comments:

Intitial Treatment Plan

Client Name:	ID #:

Client Agreement and Signatures Check if Guardian Does Not Apply ☐

ANIMAL ASSISTED SUPPORT SERVICES

2. Client and Guardian, if applicable, agree that client will participate in animal-assisted support services (if indicated) to address client symptoms and to enhance functioning in the community setting upon recommendation of a licensed clinical social worker or licensed counselor or higher level professional.

Client Name	Date	Guardian Name	Date

The below signatures are evidence that this form has been filled out and reviewed with the full consent and input of the client (*and if indicated, their legal representative*) for which the services are to be provided. All information is correct to the best knowledge of the client and guardian.

Client Name	Date	Guardian Name	Date

☐ **Check here if the assessment indicates that client is eligible for PRP Services**

Completed by:		
Staff Person Name	Title/Job Position	
Staff Person Signature:	Credentials:	Date:

Client Name:	ID #:

AGREEMENT TO PARTICIPATE IN ONSITE & OFFSITE PRP SERVICES

(Check one)

○ **OPTION 1**

Client and Guardian, if applicable, agree that client will participate in **BOTH ONSITE (office) and OFFSITE (home and community)** PRP services as indicated to be provided by Behavioral Health & Leadership Dynamics, LLC (BHLD) or it's agents.

○ **OPTION 2**

Client and Guardian, if applicable, agree to receive **ONLY ONSITE** PRP services to be provided by Behavioral Health & Leadership Dynamics, LLC (BHLD) or it's agents.

○ **OPTION 3**

Client and Guardian, if applicable, agree to receive **ONLY OFFSITE** PRP services to be provided by Behavioral Health & Leadership Dynamics, LLC (BHLD) or it's agents.

Client Name	Guardian Name
Date	Date