THE Southern Maryland Community NETWORK

Champions of Behavioral Health

CALVERT COUNTY
305 Prince Frederick Blvd.
Prince Frederick, MD 20678
(410) 535-4787 Office
(410) 535-4965 Fax

ST. MARY'S COUNTY
41900 Fenwick Street, Suite 5
Leonardtown, MD 20659
(301) 475-9315 Office
(301) 475-9317 Fax

CHARLES COUNTY
2670 Crain Highway, Suite 505
Waldorf, MD 20601
(301) 932-9146 Office
(301) 932-9361 Fax

IHIP PROGRAM **PRP for Minors** **1915i Waiver**

Demographic Information **Referral Date:** _____

Child's Name:_____ **Date of Birth:** _____ **Age:**_____

SS#:_____ **Sex:**_____ **Race:**_____

Address:_____ **City** _____ **State**_____ **Zip**_____

County of Residence:_____ **Phone Number:**_____

Parent/Guardians Name:_____

Address (if Different from Child): _____

City_____ **State**_____ **Zip**_____

Home phone:_____ **Work Phone:** _____

Marital status: ☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Widowed**
Living with significant other **Living with relative** **Foster Family**

Other (Please describe) _____

Names and ages of all household members:_____

_____

Spirituality:_____

Insurance Information

Medical Assistance Number: _____

Private Insurance Company: _____ **Policy Number:** _____

Address: _____

Referral Source

****Minor must be in active mental health treatment with a licensed professional to be served by PRP services.****

Name of referring Person: _____ **Credentials/Title:** _____

Address: _____ **City** _____ **State** _____ **Zip** _____

Phone: _____ **Organization:** _____

Signature of Licensed Mental Health Professional including credentials/title: _____

_____

Therapist agrees the minor's life skills can be expected to improve through medically necessary Rehabilitation services. ☐ **Yes** ☐ **No**

Court Ordered (If yes, note Court and Contact Name): ☐ **Yes** ☐ **No**

_____

Reason for Referral: _____

_____

This minor is judged to be in enough behavioral control to be safe in PRP:
☐ **Yes** ☐ **No**

What places the child at risk of being placed out of the home at this time? _____

_____

Has this referral been reviewed/discussed with the consumer's parent/guardian?
☐ **Yes** ☐ **No**

Signature of Parent/Guardian: _____

Education

Child's School: _____ **Grade:** _____

Special Education Needs: _____

School Psychologist: _____ **Phone:** _____

Clinical Information

Outpatient Therapist: _____ **Phone:** _____

Please check the outpatient therapist's credentials below:

LGSW ☐ **LCSW** ☐ **LCSW-C** ☐ **LGPC** ☐ **LCPC** ☐ **PhD** ☐ **PsyD** ☐

Address: _____

Outpatient Psychiatrist: _____ **Phone:** _____

Address: _____

DSM V diagnosis code: _____

Current Medication (dosage and time): _____

_____

_____

Previous Hospitalizations/ RTC/ Out of Home Placements (Include Location and dates):

_____

_____

_____

Presenting Problems (Please circle all that apply as well as frequency)

Anger Management
Mild Moderate Severe
Frequency

Conflict resolution
Mild Moderate Severe
Frequency_____

School refusal
Mild Moderate Severe
Frequency_____

Poor daily routines
Mild Moderate Severe
Frequency_____

Poor hygiene
Mild Moderate Severe
Frequency_____

Running away
Mild Moderate Severe
Frequency_____

Sexualized behaviors
Mild Moderate Severe
Frequency_____

Sexual abuse Suspected
Mild Moderate Severe
Explain_____

Sexual abuse confirmed
Mild Moderate Severe
Explain_____

Parent/ family loss
Mild Moderate Severe
Frequency_____

Self-Injurious
Mild Moderate Severe
Frequency_____

Fighting
Mild Moderate Severe
Frequency_____

Sibling Conflict
Mild Moderate Severe
Frequency_____

Peer conflict
Mild Moderate Severe
Frequency_____

Medication compliance
Mild Moderate Severe
Frequency_____

Poor social Skills
Mild Moderate Severe
Frequency_____

Neighborhood safety
Mild Moderate Severe
Frequency_____

Breaking Curfew
Mild Moderate Severe
Frequency_____

Drug use
Mild Moderate Severe
Frequency_____

Physical abuse suspected
Mild Moderate Severe
Frequency_____

Physical abuse confirmed
Mild Moderate Severe
Frequency_____

Property destruction
Mild Moderate Severe
Frequency_____

Abuse of pets
Mild Moderate Severe
Frequency_____

Firearms in the home
Mild Moderate Severe
Explain

Parent/child conflict
Mild Moderate Severe
Frequency_____

Suicidal ideation
Mild Moderate Severe
Frequency_____

Suicide attempts
Mild Moderate Severe
Frequency_____

Homicidal ideation
Mild Moderate Severe
Frequency_____

Homicidal attempts
Mild Moderate Severe
Frequency_____

Physical aggression
Mild Moderate Severe
Frequency_____

Verbal aggression
Mild Moderate Severe
Frequency_____

DSS involvement
Mild Moderate Severe
Frequency_____

Impulsive
Mild Moderate Severe
Frequency_____

Stealing
Mild Moderate Severe
Frequency_____

Injury to others
Mild Moderate Severe
Frequency_____

Fire Setting
Mild Moderate Severe
Frequency_____

Please attach the following documentation to assist us in processing this referral:

_____Psychiatric Evaluation _____Release of Information

_____Letter of recommendation for IHIP services

Please review to make sure you have completed **ALL** sections of this referral. A member of the IHIP-C or PRP team will be in contact with the referral source and family upon review. If you have further questions or concerns, please contact the Program Coordinator:

IHIP-C – **Calvert County**: Program Coordinator, 410-535-4787 ext. 333

PRP **– Calvert County**: Program Coordinator, 410-535-4784 ext. 318

IHIP-C & PRP **– St. Mary's County**: Program Coordinator, 301-475-9315 ext. 11

IHIP-C & PRP **– Charles County**: Program Coordinator, 301-932-9146 ext. 105

Fax the completed referral form with attached documentation to:

CALVERT COUNTY	CHARLES COUNTY	ST. MARY'S COUNTY
Local Behavioral Health Authority 1020 N Prince Frederick Blvd., Suite 300 P.O. Box 980 Prince Frederick, MD 20678 (443) 295-8584 ext. 104 Fax (443) 968-8979	Local Behavioral Health Authority 10480 Theodore Green Blvd. P.O. Box 1050 White Plains, MD 20695 (301) 609-5753 Fax (301) 609-5749	Local Behavioral Health Authority 21580 Peabody Street P.O. Box 316 Leonardtown, MD 20650 (301) 475-4330 Fax (301) 363-0312