THE SCHAPIRO TRAINING & EMPLOYMENT PROGRAM

Goodwill prepares people to secure and retain employment and build successful independent lives

REFERRAL FORM

If possible, please forward Psychiatric Background Information with Referral

(Please clearly print and complete all information)

☐ 222 E. Redwood ST. **(Baltimore Office)** Baltimore MD 21202 (410) 837-1800 - Office (410) 837-8931 - Fax	☐ 257 East Main Street **(Carroll Co. Office)** Westminster MD 21157 (410) 848-7793 - Office (410) 875-3371 - Fax

Date Referral Received _____ Staff Assigned _____

SEP Start Date_____ SEP Referral Date _____ PRP Start Date_____ PRP Referral Date_____

Date: _____

_____

Referral Source: _____ Signature:_____

Address: _____ Phone #: _____

Being referred for: ☐ Supported Employment ☐ PRP

Client Name: _____ Social Security #: _____

Last First MI Maiden

Address: _____

Street City County State Zip

Date of Birth: _____ Age: _____ Home Phone: _____ Cell Phone: _____

Sex: ☐ 1. Male ☐ 2. Female

Hispanic Origin: ☐ 1. Yes ☐ 2. No

Race: ☐ 1. American Indian ☐ 2. Asian ☐ 3. African American ☐ 4. White ☐ 5. Other: _____

Marital Status: ☐ 1. Single ☐ 2. Married ☐ 3. Separated ☐ 4. Divorced ☐ 5. Widowed

Veteran Status: ☐ 1. Yes ☐ 2. No ☐ 3. N/A

Highest Grad completed: _____

GED: ____ Some College:____ College Grad: ____

Living Situation:

☐ 1. Private ☐ 2. Parent/Guardian ☐ 3. Other Relative

☐ 4. Other Non-Institutional ☐ 5. Other Institutional ☐ 6. Lives Alone

☐ 7. Lives with relatives ☐ 8. Lives with non-related persons

☐ Other: _____

Medical Assistance #: _____ Medicare #: _____ ☐ A or ☐ B

Type of Insurance: _____

Employment Status: ☐ 1. Employed ☐ 2. Unemployed Date Last Worked: _____

Hourly Wage: $_____ Hours per Week: _____

Most Recent Hospitalization: From _____To_____ Name of Hospital: _____

Address: _____
Street City County State Zip

Number of: Private Hospitalizations: _____ State Hospitalizations: _____

General Hospitalizations: _____

TOTAL NUMBER OF HOSPITALIZATIONS: _____

Psychiatric Evaluations: Diagnosis - **MUST** show DSM-V Code(s) & be filled out by a ***licensed practitioner***

Primary Behavioral Diagnoses: **ICD-10**

___.__ _____

Additional Behavioral Diagnoses:

___.__ _____
___.__ _____
___.__ _____
___.__ _____

Medical Diagnoses:

___.__ _____
___.__ _____
___.__ _____

Social Elements Impacting Diagnosis (Check all that apply):

☐ None
☐ Housing problems (Not Homelessness)
☐ Educational Problems
☐ Occupational problems
☐ Financial problems
☐ Other psychosocial and environmental problems
☐ Problems with access to health care services
☐ Problems related to social environment
☐ Problems related to interaction w/legal system/crime
☐ Homelessness
☐ Problems with primary support group
☐ Unknown

Functional Assessment:

Current GAF: _____

Problem with Law: ☐ Yes ☐ No (__Past *or* __Present)	Problem with Alcohol: ☐ Yes ☐ No (__Past *or* __Present)
Problem with Drugs: ☐ Yes ☐ No (__Past *or* __Present)	History of Violent Behavior: ☐ Yes ☐ No (__Past *or* __Present)

Payment Source: ☐ 1. Personal Resources ☐ 4. Medicare ☐ 5. Medical Assistance

Family Size: _____	Number of Dependent Children: _____

Emergency Contact: _____Relationship: _____

Address: _____
Street City County State Zip

Home Phone: _____Work Phone: _____

Therapist: _____Phone #: _____
Address: _____

Psychiatrist: _____ Phone #: _____
Address: _____

Family Doctor: _____ Phone #: _____
Address: _____
Currently being treated: ☐ No ☐ Yes – For? _____
Medication: _____

DORS Counselor: _____ Phone #: _____
Address: _____
Case Manager: _____ Phone #: _____
Address: _____

Psychiatric Medications (Please print clearly):

_____

_____

_____

_____

_____

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OFFICE USE ONLY

To be forwarded to Business Office **ONLY** when the First Date of Service has been changed from the date originally reported on the Referral Form

Client Name: _____ Social Security Number: _____

Primary Staff Member (Job Coach): _____ Program Element: _____

First Service Date: _____ Payment Source: _____

NOTES:

DSM – V – TR CODES FOR MHA PRIORITY POPULATION
Supported Employment Program (SEP)

INCLUDED DIAGNOSES (DSM-V Including ICD-9 and ICD-10 codes):

295.00 – 99/ F20.0-F25.9	All Schizophrenias
296.33/34/ F33.21.F33.3	Major Depressive D/O, Recurrent, Severe w & w/o psychosis
296.43/44/ F31.13/F31.2	Bipolar, Manic, Severe w &w/o psychosis
296.53/54/ F31.4/F31.5	Bipolar, Depressed, Severe w & w/o psychosis
296.63/64/ F31.63/F31.64	Bipolar, Mixed, Severe w & w/o Psychosis
296.80/ F31.9	Bipolar, NOS
296.89 / **F31.81**	Bipolar II
297.1/ F22.0	Delusional D/O
298.9/ F28.0	Psychotic D/O NOS
301.22 / **F21.0**	Schizotypal Personality D/O
301.83 / F60.3	Borderline Personality D/O

The above represents diagnoses that are accepted /required for the Supported Employment Program (SEP).

Furthermore, for SEP only, the definition is relaxed regarding the **F31.0** (affective disorder) category.

Any Major Depression, Recurrent, that is – **F33.X** will do, mild, moderate, partial remission, etc. (Must be MDD – Recurrent, NO Single episode).

Same goes for the Bipolar D/O'S that is **F31.X**, **F31.x** are good, mild, mod, remission, etc.

Thus **F33.0**, **.1**, **.2**, **.3**, **.8 and .**9 are fine, same with **F33.40, .41, .42**, and **F31.x**

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DSM-V Priority Population Diagnoses

Psychiatric Rehabilitation Program (**PRP**)

INCLUDED DIAGNOSES (DSM-V Including ICD-9 and ICD-10 codes):

295.90/F20.9	Schizophrenia
295.40/F20.81	Schizophreniform Disorder
295.70/F25.0	Schizoaffective Disorder, Bipolar Type
295.70/F25.1	Schizoaffective Disorder, Depressive Type
298.8/F28	Other Specified Schizophrenia Spectrum and Other Psychotic Disorder
298.9/F29	Unspecified Schizophrenia Spectrum and Other Psychotic Disorder
297.1/F22	Delusional Disorder
296.33/F33.2	Major Depressive Disorder, Recurrent Episode, Severe
296.34/F33.3	Major Depressive Disorder, Recurrent Episode, With Psychotic Features
296.43/F31.13	Bipolar I Disorder, Current or Most Recent Episode Manic, Severe
296.44/F31.2	Bipolar I Disorder, Current or Most Recent Episode Manic, With Psychotic Features
296.53/F31.4	Bipolar I Disorder, Current or Most Recent Episode Depressed, Severe
296.54/F31.5	Bipolar I Disorder, Most Recent Episode Depressed, With Psychotic Features
296.40/F31.0	Bipolar I Disorder, Current or Most Recent Episode Hypomanic
296.40/F31.9	Bipolar I Disorder, Current or Most Recent Episode Hypomanic, Unspecified
296.7/F31.9	Bipolar I Disorder, Unspecified
296.89/F31.81	Bipolar II Disorder
301.83/F60.3	Borderline Personality Disorder

~and~

In order to be included in the PRIORITY POPULATION, individuals must meet the target diagnostic criteria and meet the following functional limitations:

Serious mental illness is characterized by impaired role functioning, on a continuing or intermittent basis, for at least two years, including three of the following:

- Inability to maintain independent employment,
- Social behavior that results in interventions by the mental health system,
- Inability, due to cognitive disorganization, to procure financial assistance to support living in the community,
- Severe inability to establish or maintain a personal support system, or
- Need for assistance with basic living skills

The diagnostic criteria may be waived for the following two conditions:

1. An individual committed as not criminally responsible who is conditionally released from a Mental Hygiene Administration facility, according to the provisions of Health General Article, Title 12, Annotated Code of Maryland, or

2. An individual in a Mental Hygiene Administration facility with a length of stay of more than 6 months who requires RRP services, but who does not have a target diagnosis. This excludes individuals eligible for Developmental Disabilities services.

Consent For Release Of Confidential Information

I, _____ , authorize STEP/GIC
(*Client Name*)

and _____
(*Place and Address*)

to disclose to each other the following specific information:
(*It may be released or obtained in written, verbal, audio-visual or electronic forms.*)

____ Psychological Evaluation
____ Educational Evaluation
____ Psychiatric Evaluation
____ Case Summary
____ Social History
____ Treatment Plan
____ Vocational Evaluation
____ IRP/IWRP
____ Medical Data
____ Ongoing Communication
____ Employment Issues
____ Other (*Specify*) _____

The purpose of this consent is coordination of services. This consent will expire one year from date signed.

I have been informed of the type of information being sought, and the benefits and disadvantages, if any. I understand that the following may include treatment for mental and/or physical illness, counseling or treatment for drug and/or alcohol abuse, human immunodeficiency (HIV) infection, including acquired immunodeficiency syndrome (AIDS) or test for HIV or AIDS. I understand that my records are protected under Federal Law, and cannot be re-disclosed without my express or written consent, unless otherwise permitted in accordance with Federal Law and Regulations. I also understand that I may revoke this consent at any time, except to the extent that action has been taken on it.

Birth Date: _____ Date Signed: _____

SS Number: _____ _____
(*Client Signature*)

Client complete address:

_____ _____ _____ _____
(*Street Address*) (*City*) (*State*) (*Zip Code*)

Date Signed: _____

_____
(*Staff Signature*)

_____ _____
(*STEP PRP Staff Signature*) (*STEP SEP Staff Signature*)