Mid- Atlantic Development Services, LLC Referral Form

DATE OF REFERRAL:	
PROGRAM DESIRED:	**Mental Health Skill-building Services**

AREA OFFICE

Danville	

CLIENT DEMOGRAPHIC, INSURANCE, AND DIAGNOSTIC INFORMATION

Name:		**Date of Birth:**	
Address:			
Home Phone:		**Gender:**	
Cell Phone:		**Race:**	
Work Phone:		**Marital Status:**	
Social Security Number:		**Medicaid Number:**	
Additional Insurance:			

DIAGNOSTIC INFORMATION

Diagnostic Code	Diagnostic Description

LEGAL GUARDIAN/AUTHORIZED REPRESENTATIVE/POA INFORMATION (If Applicable)

Name:			**Relationship:**		
Address:					
Home Phone:		**Cell Phone:**		**Work Phone:**	

PRIMARY CARE PHYSICIAN (If Applicable)

Name:		**Company:**	
Address:			
Phone:		**Fax:**	

PSYCHIATRIST (If Applicable)

Name:		**Company:**	
Address:			
Phone:		**Fax:**	

PREVIOUS HIGHER LEVEL OF CARE/HOSPITILIZATION (If Applicable)

Name:			
Address:			
Phone:		**Fax:**	

The Client must meet all of the following:

Is the primary diagnosis schizophrenia/other psychotic disorder, Major Depressive Disorder-Recurrent, or Bipolar I or II?		YES		NO
If the primary diagnosis is not one of the above, has a physician documented any other mental health disorder within the last year to include all of the following:		YES		NO
Serious Mental Illness (SMI), Severe and recurrent disability, Functional limitations in the member's major life activities which are documented in the member's record; and Member requires individualized training in order to achieve or maintain independent living in the community.				
Does the member require individualized training in acquiring basic living skills such as symptom management; adherence to psychiatric and medication treatment plans; development and appropriate use of social skills and personal support system; personal hygiene; food preparation; or money management?		YES		NO
Does the individual have a prior history of any of the following?		YES		NO
Psychiatric hospitalization, Crisis Stabilization Services, Intensive Community Treatment (ICT), Program of Assertive Community Treatment (PACT) services, Placement in a psychiatric residential treatment facility (RTC Level C); or Temporary Detention Order (TDO) evaluation as a result of decompensation related to serious mental illness.				
Has the individual had a prescription for anti-psychotic, mood stabilizing, or anti-depressant medications within the last 12 months?		YES		NO

REFERRING PARTY NAME:		**REFERRING AGENCY:**	
MAILING ADDRESS:			
TELEPHONE NUMBER:		**E-MAIL ADDRESS:**	
If Self-Referral, how did you hear about Mid Atlantic Development Services, LLC:		**If receive Waiver Services, which type:**	
Person Taking Referral (if applicable):			

Mid- Atlantic Development Services, LLC Office Use:

Date Referral Received:		**Date Medicaid Confirmed:**	
Date Assigned for Assessment:		**Staff Assigned to Do Assessment:**	
Date Assessment Accomplished:		**Outcome of Assessment:**	
Date Pre-Authorization Received:		**Pre-Authorization Number:**	