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ELIGIBILITY/REFERRAL, SCREENING, AND ADMISSION FORM

COMAR 10.63

Individual is a participant in the public mental health system (must check yes), COMAR 10.63.

PART I: BASIC INFORMATION, COMAR 10.63

Consumer: ________________________________
First Last MI

Sex: ☐ Male ☐ Female ☐Other

Race: ______________________________

SSN: ______________________________________

DOB: ______________________________________

Address:___________________________

City: _______________ State: _________

Zip Code: _________ - _________

Consumer Phone Number: _________________

Sexual Orientation: ______________________

Date of Admission, COMAR 10.63: ____________

Source of Referral, COMAR 10.63:
Referred by______________________________
Agency Name & Address: ____________________
____
____

Referral Phone Number: _______________

What date will the consumer need a crisis bed? ______

Veteran Status: ☐ Yes ☐ No

*Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced

Is the consumer employed? ☐ Yes ☐ No

If so, name of employer: ____________________

Does the consumer receive SSI or SSDI? ☐ Yes ☐ No

Any form of income? ☐ Yes ☐ No How Much?_____

Medical Assistance #: ___________________________

Does the client have Medicare? ☐ Yes ☐ No

If so, Medicare type and #: ___________________

Emergency Contact/Relationship: ___________________

Phone Number: __________________________

Emergency Contact's Address: _____________________

PART II: DIAGNOSIS, COMAR 10.63.

Axis 1: ___________________________________ has been evaluated by __________________ (Physician or Licensed Mental Health Professional) COMAR 10.63 and is in need of Crisis Residential Services in order to: ______________

Current GAF: _______________ Highest GAF in the Past Year: ____________________

ELIGIBILITY, REFERRAL, SCREENING, AND ADMISSION FORM

A ____ Inpatient Admission Prevention, which provides services to a consumer who, based on the consumer's history, is evaluated by a physician or mental health professional, has a mental disorder and, without SJH, is at risk for inpatient admission or cannot be discharged from an inpatient facility, COMAR 10.63.

OR

B ____ Inpatient Admission Alternative, which provides services to a consumer who, based on an evaluation by a physician or mental health professional, has a mental disorder**, presents a danger to self or others, and would, without SJH**, be admitted to or could not be discharged from an inpatient facility, COMAR 10.63.

PART III: DETAIL OF SYMPTOMS

Please fill out the following questions

1. List current symptoms that lead consumer to being at risk? Please be specific (COMAR 10.63)
   ____
   ____
   ____

2. What specific factors contributed to the current crisis? (COMAR 10.63)
   ____
   ____
   ____

3. Eligibility Checklist (ALL must be checked):
   _____ Has a diagnosis that is listed on the Priority Population list (COMAR 10.63)
   _____ Due to acute symptomology related to the individual's psychiatric condition has impaired ability to function within the individual's community living situation and is in need of RCS to avoid inpatient psychiatric admission or to shorten the length of inpatient stay, (COMAR 10.63)
   _____ Requires separation from living situation due to symptoms of illness, (COMAR 10.63)
   _____ Willing to comply with all programs rules, (COMAR 10.63)
   _____ Expects, with staff support, to be able to comply with treatment recommendations, (COMAR 10.63)
   _____ Can and will complete ADL's independently, with staff support, (COMAR 10.63)

****AN INDIVIDUAL IS NOT ELIGIBLE IF HE/SHE:** (COMAR 10.63) **(a) has a sole diagnosis of substance use, major neurocognitive disorder (ex: dementia, intellectual disability); (b) is in need of immediate involuntary inpatient psychiatric admission; or (c) is medically unstable, as determined under the Health Occupations Article, Annotated Code of MD. A consumer cannot be excluded if he/she is homeless.**

Current Suicidal/Homicidal Ideation: No ____ Yes ______________________________
If yes, explain details of ideations (when, plan, means)______________________________

Current Symptoms are: ☐ SEVERE ☐ INTENSE ☐ MODERATE

Signs of decompensation: ____
____
____

Mental Health Treatment, (COMAR 10.63):

Current/Past Hospitalizations: Past Month ___________ Past Year ___________ Past 5 Years ___________

Current Outpatient Providers: ____

1. Preliminary Discharge Plan for the Consumer after discharging from Safe Journey House, to be completed by a Licensed Mental Health Professional, (i.e. substance abuse treatment, long term housing, titration of medication, monitoring of high blood pressure and/or blood sugar, etc.), COMAR 10.63**:**

2. Please describe the level and type of staff support required for the Consumer within the first 48 hours of admission, (COMAR 10.63):

3. Which of the following enhanced supports is needed? (COMAR 10.63)

☐ **24 hours on site** ☐ **24 hours on site, awake** ☐ **24 hours, one-to-one**

PART IV: MEDICATIONS

Substance Abuse, (COMAR 10.63)

Currently Abusing: ☐ No or ☐ Yes, which substance? ____

Last Use Date_______________ Frequency of use____

Physical Health

Current medical conditions: ____

Date of consumer's most recent COVID 19 test: _______________________________________

Current monitoring needs (Diabetes, HTN): ____

Does the Consumer have a history of, or any current airborne communicable disease (ie Tuberculosis, Legionellosis, Meningococcal disease, and Pneumococcal infections?) ☐ No or ☐ Yes,

____

Is the consumer medically stable? ☐ N ☐ Y Allergies ____

Is the consumer ambulatory? ☐ N ☐ Y If no, what assistance is needed? ______________________

Medications, (COMAR 10.63)

Current Psychotropic Medications

Name	Dosage	Frequency

Is the consumer on a long acting injectable? If yes, when was the last injection given? ___________________________________

Current Somatic Medications

Name	Dosage	Frequency

VERIFY (Yes/No):

____ Lab work (blood levels for consumers on Depakote/ Lithium/Clozaril)

Securing Medications

Authorization

Insurance Approval (Optum): 1-800-888-1965

☐ Authorization has been obtained for _______ days. Authorization# ______________________

Dates approved: _____________ to ______________.

OR

☐ Authorization cannot be obtained by us (referral source) and will need to be completed by SJH.

Consumer with Medical Assistance (MA)

☐ Prescriptions are filled and consumer will be arriving with them **OR**

☐ Prescriptions were faxed to ______________ pharmacy at ______ am /pm

Consumer with NO Insurance

☐ The consumer will be arriving with ________ (5, 10, 20, or 30) days of medication.

OR

☐ Medication Assistance to Purchase application faxed to ______________________ County's Local Behavioral Health Authority by: __________

Physician Signature & Credentials ___________________________________ Date _____________ COMAR 10.63

Referrer's Signature & Credentials ___________________________________ Date _____________ COMAR 10.63

Consumer's Signature ____ Date _____________ COMAR 10.63