

**Mental Health Skill-Building/PSR Services Referral Form**

**Name (First, Middle, Last): DOB: \_ \_\_\_**

**Address:**

**Phone #: \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Marital Status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Race:\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**[ ] Parent** **[ ] Guardian** **[ ] AR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medicaid Number\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Verified**

**Referral Source: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Check service that individual is interested in:**

 **MHSS PSR Payee Services**

**Has the individual been legally adjudicated as incompetent?** **[ ] Yes** **[ ] No**

**Does the individual have a case manager through the Community Services Board?**

**[ ] Yes [ ] No If yes, list CSB and case manager name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is the individual receiving in-home residential services or congregate residential services through ID waivers?** **[ ]  Yes** **[ ]  No**

**Is member residing in ICF/IDs or hospitals? Does the individual receive Treatment Foster Care, Independent Living Skills Services, in an Independent Living Program through DSS, in an Independent Living Arrangement or any living skills program?**

**[ ]  Yes** **[ ]  No**

**Individual must meet ALL FOUR of the following to qualify for services:**

1. **Diagnostic information (If not diagnosed with schizophrenia or another psychotic disorder, bipolar I or II, Major Depressive Disorder, Recurrent, specify whether a physician has documented the individual’s need for services):**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **Does the individual require training in acquiring basic life skills? Specify:**

**[ ]  Symptom management, medication adherence**

**[ ]  Access to medical care**

**[ ]  Development and appropriate use of social skills and support system**

**[ ]  Use of community resources**

**[ ]  Personal hygiene, maintenance of a safe and sanitary home**

**[ ]  Grocery shopping, food preparation, adequate nutrition**

**[ ]  Money management**

**Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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1. **Does the individual have a history of psychiatric hospitalization, residential crisis stabilization, ICT, PACT, placement in an RTC Level C, or TDO?**

**Specify facility names and dates:**

**\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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1. **Has the individual had a prescription for anti-psychotic, mood stabilizing, or antidepressant medications within the last 12 months?**

**List medication names and prescribing physician:**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Person completing this form:**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Documentation of attempts to contact (initial each date, time, and method):**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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