

HOWARD COUNTY MENTAL HEALTH AUTHORITY
APPLICATION FOR RESIDENTIAL REHABILITATION SERVICES

TAY

ADULT

Today's Date: _____

(I) Applicant's Name: _____
(Last) (First) (M.I.)

Address: _____
(Last known address in community)

Home #: _____ Mobile #: _____ Pager #: _____

Work #: _____ Other #: _____

Date of Birth: _____ Social Security #: _____

Gender: _____ Race: _____ Marital Status: _____

Current Entitlements and Income (Fill in amounts and/or insurance numbers)

SSI: _____ SSDI: _____ Other Income: _____

Medicaid (MA): _____ Medicare: _____

Other Insurance Name & Number: _____

(II) Referral Source Name: _____ Agency: _____
Telephone #: _____ Fax: _____

Psychiatrist Name: _____ Telephone #: _____

Other Providers (Mobile Treatment, PRP, Case Management, Outpatient) - (please circle)

<u>Name of Program</u>	<u>Contact Person</u>	<u>Telephone #</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Primary Contact (applicant, therapist, family member, friend, other)-(please circle)

<u>Name of contact</u>	<u>Telephone #</u>	<u>Relationship to Applicant</u>
_____	_____	_____

(III) Current Psychiatric Diagnosis: _____ DSM-IV Code: _____

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: (GAF) _____

Number of psychiatric hospitalizations: _____

Date, Location & Length of Stay: _____

Applicant's Name: _____

DOB: _____

(IV) Name of Primary Care Physician (PCP): _____
 Address: _____
 Telephone #: _____
 Significant Somatic Issues: _____

(V) All Current Medications: (Psychiatric and Somatic)

<u>Type</u>	<u>Dosage/Frequency</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Current ability to take medicine:

Independently _____ With reminders _____ With daily supervision _____

Refuses medications _____ Medications not prescribed _____

Comments: _____

(VI) Legal history/Forensic Involvement

Has the applicant ever been arrested? Y _____ N _____

On Probation or Parole? Y _____ N _____

List any reported convictions: _____

Has applicant been found NCR (Not Criminally Responsible)? Y _____ N _____

Is on (or will be) on Conditional Release Y _____ N _____

(VII) Substance Use/Abuse History

Drug Used (including alcohol)	Period of Use	Frequency/Cost	How Used
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Drug Last Used	Date	Amount	How Used
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Substance Abuse Treatment History (date and location)

A.A. _____ N.A. _____

Detox _____

Inpatient Services _____

Outpatient Services _____

Applicant's Name: _____

DOB: _____

(VIII) Risk Assessment (Never, past week-month, past month-year, past 2+ years)

Suicide Attempts: _____

Suicide Ideations: _____

Aggressive Behavior/Violence: _____

Fire Setting: _____

(IX) Activities of Daily Living

_____ Independent _____ Needs moderate support _____ Needs significant support

(X) Previous RRP involvement? Yes _____ No _____ If yes, reason for discontinuation of RRP:

Consumer preference of provider _____

Cultural preference of consumer _____

(XI) Rationale for Service:

(Please include major areas of need and applicant's goals for RRP)

Recommended Level of Residential Placement:

_____ General Level _____ Intensive Level _____ Intensive/24 Level

General Level: Residential staff provides a minimum of three face-to-face contacts per consumer at the residence. This level of care is flexible based on the changing needs of the consumer not to exceed 13 face-to-face contacts per month. In case of an emergency or the need for staff intervention, staff is on call twenty-four hours per day, seven days per week.

Intensive Level: Residential staff provides daily supervision and support at the residence. This level of care is flexible based on the changing needs of the consumer for a minimum of forty hours per week or more depending on the needs of the consumer. Staff is on call twenty-four hours per day, seven days per week.

Intensive/24 Level: This level of care is for a consumer who needs more staff supervision, monitoring and support during the night hours in addition to needing intensive supervision during the day. Staff is on call twenty-four hours per day, seven days per week.

(XII) Is the applicant in agreement with the above referral? _____ Y _____ N

If "No", explain: _____

Date

Referral Source Signature

Applicant's Name: _____

DOB: _____

**CONSENT TO RELEASE INFORMATION
FOR RESIDENTIAL PLACEMENT**

I give my consent to the **HOWARD COUNTY MENTAL HEALTH AUTHORITY (CSA)** to release this application and other clinical and psycho-social history to a Residential Rehabilitation Program in order to assess my eligibility for residential services in the community.

I understand that this information will not be released to any other party without my express written consent.

I further understand that my consent does not commit me to accept a placement, and it does not commit the Core Service Agency to provide a placement for me.

I understand that I may revoke this consent at any time by a written statement. This consent is valid for 12 months from the date of my signature.

Signature: _____

Date: _____

Social Security #: _____

Date of Birth: _____

Witness: _____

Date: _____

HOWARD COUNTY MENTAL HEALTH AUTHORITY

9151 Rumsey Road, Suite 150
Columbia, MD 21045

Phone: 410-313-7350
Fax: 410-313-7374

Community Service Team for Residential Services Authorization of Disclosure

I give my consent for the exchange of verbal information among members of the Community Service Team (CST) needed for consideration for evaluation and placement into a residential program. I also give my consent for the release of the following written information from _____ to the Community Service Team.

(Signature)

(DOB)

(Date)

- Multidisciplinary Admission Assessment
- Annual Assessment
- Psychological Testing, if available
- Current Treatment Plan and Recommendation
- Physical/Medical Examination
- Current Medications
- Previous Medications

Other:

- Substance Abuse History
- Admission Summary
- Discharge Summary

The Howard County Mental Health Authority chairs the Community Service Team (CST), which is responsible for developing and managing mental health services in Howard County. The CST consists of representatives from the following agencies: Humanim, Inc., Prologue, Inc., WayStation @ Howard County, Springfield Hospital Center, Grassroots Crisis Intervention, Alliance, Inc., and other authorized mental health providers as needed to address an individual's needs.

Prohibition of Redisclosure: This information has been disclosed to us from your records whose confidentiality is protected. Any further disclosure is prohibited.

Signature of Applicant: _____

Date: _____

Witness: _____

Date: _____

Relationship of Witness: _____

Parent/Legal Guardian: _____
(If applicable)

Date: _____

HOWARD COUNTY MENTAL HEALTH AUTHORITY

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Columbia, MD 21045

Phone: 410-313-7350
Fax: 410-313-7374

Authorization of Disclosure For Howard County Mental Health Authority

I, _____, give my consent for the exchange of written and verbal information to the providers listed below for the purpose of **applying for a residential rehabilitation program bed in Howard County, MD.**

Clinic: _____ Telephone/Contact: _____

Hospital: _____ Telephone/Contact: _____

Hospital: _____ Telephone/Contact: _____

Program: _____ Telephone/Contact: _____

Family/Interested Parties: _____

_____ Telephone/Contact: _____

Other: _____ Telephone/Contact: _____

- | | |
|---|--|
| <input type="checkbox"/> Annual Assessment | <input type="checkbox"/> Medications |
| <input type="checkbox"/> Current Treatment Plan Recommendations | <input type="checkbox"/> Physical \Medical Examination |
| <input type="checkbox"/> Discharge/Treatment Summary | <input type="checkbox"/> Psychological Testing (if applicable) |
| <input type="checkbox"/> Multidisciplinary Admission Assessment | <input type="checkbox"/> Substance Abuse History |
| <input type="checkbox"/> Other: _____ | |

Re-disclosure of information provided to these providers is prohibited.

Signature of Applicant: _____ Date: _____

Witness: _____ Date: _____

Relationship of Witness: _____

Parent/Legal Guardian: _____ Date: _____
(if applicable)

Please return information to:

Howard County Mental Health Authority
9151 Rumsey Road, Suite 150
Columbia, MD 21045
(410) 313-7350 Fax (410) 313-7374

Developed 1999
Revised 2/02
11/13/03
11/21/03
General Consent 11/24/03