

Maryland Healthy Transitions (MD-HT) APPLICATION FORM INSTRUCTIONS

Maryland Healthy Transitions (MD-HT) provides supportive services to Transition Age Youths – young adults ages 16-25. The goal of Maryland Healthy Transitions (MD-HT) is to provide services that will support an individual to achieve milestones and make progress on goals for independent living, completing high school and/or starting post-secondary education, getting and keeping competitive paid employment, and learning to navigate supports with and from family members and professionals. Maryland Healthy Transitions (MD-HT) provides staff support around areas of personal needs such as independent living skills, symptom management, stress management, relapse prevention planning, employment, education and/or vocational services, crisis prevention and other services that will help with the individual's recovery.

Please see the enclosed Maryland Healthy Transitions (MD-HT) application.

- The mental health professional and/or mental health provider who works most closely with the applicant may assist the applicant in completing the attached forms. A licensed mental health professional must complete the attached Referral Form. If you are also requesting PRP, the applicant must have a Priority Population Diagnosis (lists attached).
- Applicant must sign the Consent For Release of Information for MD-HT Services Form
- Medical Necessity Criteria must indicate why the applicant cannot function independently in the community without mental health services.
- Priority is given to in-county residents. This referral does not guarantee placement. Eligibility and need will be reviewed and determined by the Core Service Agency (CSA) for the county of residence.
- **The application must be sent to the Core Service Agency (CSA)** of the applicant's home origin (based upon the applicant's current or last known address in the community prior to inpatient hospitalization, incarceration, residential crisis bed or current state of homelessness). Please mark the envelope or fax cover sheet: Attn: MD-HT Referral

County of Residence	CSA Agency	Service Provider
Charles County Calvert County & St. Mary's County	Department of Health Core Service Agency P.O. Box 1050, 4545 Crain Hwy. White Plains, Maryland 20695 Phone: 301-609-5757 Fax: 301-609-5749	Pathways, Inc. P.O. Box 129 Hollywood, MD 20601 Phone: 301.373.3065 Fax:
Howard County	Howard County Mental Health Authority 9151 Rumsey Road, Suite 150 Columbia, Maryland 21045 Phone: 410-313-7350 Fax: 410-313-7374	Humanim 6355 Woodside Court Columbia, MD 21046 Phone: 410-381-7171 Fax: 410-381-0782

Maryland Healthy Transitions (MD-HT) APPLICATION

APPLICANT'S HOME ORIGIN: Please select the applicant's home county/city (based upon the applicant's current or last known address in the community prior to inpatient hospitalization, incarceration, residential crisis bed or state of homelessness i.e. eviction, couch-surfing, motel, etc.

<input type="checkbox"/> Calvert County	<input type="checkbox"/> Charles County	<input type="checkbox"/> Howard County	<input type="checkbox"/> St. Mary's County
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Applicant Information: Please complete this section. If there is a section that is unknown to the referral source, indicate with "N/A".

Applicant's Name: Last:		First:	M.I.
Address: (Current or Last Known)		Phone Numbers: Mobile:	
Please check if: <input type="checkbox"/> Shelter <input type="checkbox"/> Temporary Housing		Home:	
Homeless: <input type="checkbox"/> Yes <input type="checkbox"/> No		Alternate or Email:	
Date of Birth (MM/DD/YYYY): Age:		Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Sexual Orientation (Optional):	Race:		Marital Status:
Primary Language:	Interpreter Required: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Legal Resident	
Highest Level of School Completed:			
Employment Status:			
Mental Health Diagnoses (please list all you and your doctor have identified):			
What stands in the way of you completing the things you need to do?			
Why are you applying for services? What are your goals?			
What daily activities and skills do you want assistance with or do you think you don't do well when you are not feeling well. Please check all that apply:			
<input type="checkbox"/> Personal hygiene and grooming <input type="checkbox"/> Food preparation <input type="checkbox"/> Making healthy food choices <input type="checkbox"/> Meeting new people <input type="checkbox"/> Using supports <input type="checkbox"/> Doing well in school <input type="checkbox"/> Staying safe	<input type="checkbox"/> Exercising <input type="checkbox"/> Keeping room/home clean <input type="checkbox"/> Managing money, budgeting <input type="checkbox"/> Getting along with friends <input type="checkbox"/> Getting/using resources <input type="checkbox"/> Using transportation Other:	<input type="checkbox"/> Following housing rules <input type="checkbox"/> Taking medications consistently <input type="checkbox"/> Accessing resources <input type="checkbox"/> Getting along with family <input type="checkbox"/> Getting and keeping jobs <input type="checkbox"/> Making good decisions Other:	

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Somatic/Physical Health Diagnoses or Concerns:

Previous History of Drug and Alcohol Use (please include type, when used, in what amount, and how used):

Current Drug and Alcohol Use (please include type, when used, in what amount, and how used):

Current Medications – type, frequency, dose and reason for taking:

Have you been hospitalized for mental health reasons: yes no

If yes, list dates, duration and reasons:

Have you been hospitalized or received inpatient treatment for substance use: yes no

If yes, list dates, duration and reasons:

Have you ever lived in a Residential Rehabilitation Program (RRP) or Residential Treatment Center (RTC)?

yes no

If yes, list location and dates:

Have you ever been arrested: yes no

If yes, are you currently on parole/probation: yes no

Current Providers and Supports: (or most recent if not currently in treatment)

Name/Title:	Agency/Program	Contact Information:
Psychiatrist/Prescriber:		Telephone #: Fax #: Email:
Therapist:		Telephone #: Fax #: Email:
Referral Source (if different):		Telephone #: Fax #: Email:
Other Providers (Mobile Treatment, Psychiatric Rehabilitation, Case Management, Transition Teachers) :		Telephone #: Fax #: Email:

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Primary Care Physician:		Telephone #: Fax #: Email:
Emergency Contact:	Relationship to you:	Telephone #: Fax #: Email:
Current Income and Entitlements (to determine financial eligibility):		
Type of Income	Amount (Monthly)	Status
Supplemental Security Income (SSI)	\$	<input type="checkbox"/> Receiving <input type="checkbox"/> Applied - Pending <input type="checkbox"/> Applied - Denied
Social Security Disability Insurance (SSDI)	\$	<input type="checkbox"/> Receiving <input type="checkbox"/> Applied - Pending <input type="checkbox"/> Applied - Denied
Temporary Disability Allowance Program (TDAP)	\$	<input type="checkbox"/> Receiving <input type="checkbox"/> Applied - Pending <input type="checkbox"/> Applied - Denied
Veteran's Benefit (VA)	\$	<input type="checkbox"/> Receiving <input type="checkbox"/> Applied - Pending <input type="checkbox"/> Applied - Denied
Employment Earnings	\$	# Of Hours Worked:
Other Income:	\$	<input type="checkbox"/> Receiving <input type="checkbox"/> Applied - Pending <input type="checkbox"/> Applied - Denied
Type of Insurance	Insurance/Policy #	Status
Medical Assistance (MA)	#	<input type="checkbox"/> Receiving <input type="checkbox"/> Applied - Pending <input type="checkbox"/> Applied - Denied
Medicare (MC)	#	<input type="checkbox"/> Receiving <input type="checkbox"/> Applied - Pending <input type="checkbox"/> Applied - Denied
Other Insurance:	#	<input type="checkbox"/> Receiving <input type="checkbox"/> Applied - Pending <input type="checkbox"/> Applied - Denied
<input type="checkbox"/> No Insurance		

Maryland Healthy Transitions (MD-HT)
CONSENT TO RELEASE INFORMATION

I give my consent to _____(provider) to release to and obtain information from _____ (CSA), regarding this application and other clinical and psycho-social history in order to assess my eligibility for MD-HT services in the community.

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

I understand that my consent does not commit me to accept services and it does not commit the provider to provide services to 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.

Applicant's Signature: _____ Date: _____

Parent's Signature: _____ Date: _____
(Recommended if applicant is under 18)

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REFERRAL FORM

Applicants: Please give this and the following pages to your mental health professional(s) (therapist or prescriber) All applicants must get this form completed to be eligible for services. This form must include a Priority Population Diagnosis listed as the primary if you would like additional Psychiatric Rehabilitation Program (PRP, sometimes called Supported Living or Case Management) Services. If you are not currently receiving clinical services from a mental health professional but would like to be, get your most recent healthcare providers to complete this form MD-HT service providers will be able to assist you with getting new services after you are enrolled.

Clinicians: The information in this form will be used to determine whether the applicant meets the Medical Necessity Criteria for grant-funded services. ***Please complete to the best of your ability and elaborate wherever possible.*** Clearly demonstrated Medical Necessity is required for your patient/consumer to get services funded.

Applicant's Name:	Date of Birth:
Clinician's Name & Credentials:	Preferred Contact (Phone # and/or E-mail):

Primary Diagnosis: Please see attached lists of eligible diagnoses. The Priority Population Diagnosis must be listed first.	ICD-9 or ICD-10 Codes:
Primary: _____	_____
Secondary/Additional Diagnoses - please list all: _____ _____ _____ _____ _____	_____ _____ _____ _____ _____
Medical/Somatic Diagnoses: _____ _____ _____ _____ _____	_____ _____ _____ _____ _____
Other Conditions that may be a Focus of Clinical Attention: _____ _____ _____	_____ _____ _____

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Current Medications (if known; please list name, dosage, frequency, administration, and purpose):

Psychiatric Hospitalizations - if known please list hospitals and dates of admissions:

Medical Necessity Criteria - *Factors or Criteria justifying the need for MD-HT TAY Services and associated funding:*

The individual has a PBHS Specialty Mental Health diagnosis, as described in the DSM-5, e.g., 1) a psychotic disorder (e.g., Schizophrenia, Schizoaffective Disorder), 2) a major mood disorder (e.g., Major Depressive Disorder, Bipolar Disorder, 3) a major anxiety disorder (e.g., Agoraphobia, Generalized Anxiety Disorder, Obsessive Compulsive Disorder, Panic Disorder, Post Traumatic Stress Disorder, Social Phobia). The following Childhood Disorders may be present, but may not be the sole diagnosis: Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, Conduct Disorder, or Learning Disorder. Exceptions to the diagnostic requirement may be made, on a case by case basis, for youth and young adults who do not have a TAY priority population diagnosis but who do have a history of Residential Treatment Center placement, or a history of multiple psychiatric hospitalizations.

Impairments related to this disorder have resulted in **at least one** of the following:

- A clear, current threat to the individual's ability to function independently in the community or to live or be retained in his or her customary setting.
- A significant inability to effectively negotiate the developmental tasks of emerging adulthood, to achieve developmental milestones, or to assume normative adult roles, including but not limited to: exploring and discovering opportunities for employment, school, housing, and social/family relationships, and making life course decisions. This significant inability, or dysfunction, is not solely defined as the failure to fully meet societal expectations of independence, such as residential stability, stable employment, progressive educational attainment and school completion, or the establishment of mature interpersonal and/or family relationships.
- A significant inability to manage the symptoms of one's illness and concomitant psychosocial stressors or to modulate one's behavior in response to social cues or societal norms (not manifested primarily by criminal behavior).

Please Explain:

Current presentation of symptoms related to this disorder include or have contributed to **at least two** of the following:

- History of psychiatric hospitalization
- Residential Treatment Center placement
- Multiple system-level involvement and/or residential care
- Substance use/abuse
- Aggressive behavior
- Behaviors resulting in danger to self or others
- Psychosis/ Poor reality testing
- High levels of impulsivity, poor judgment, and inability to self-protect in community situations

Please Explain:

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Based on your assessment, **all** of the following are true:

- The individual, due to dysfunction, is at risk for requiring a higher level of care, or is returning from a higher level of care.
- The individual's disorder can be expected to improve through medically necessary HT TAY services or there is clinical evidence that this intensity of services is needed to maintain the individual's level of functioning; and
- The individual is judged to be in enough behavioral control to be safe in the HT TAY program and benefit from the services provided.

Please Explain:

The individual understands the following HT TAY Service Requirements:

- In order for HT TAY services to be safe/therapeutic for an individual, professional and/or social/natural supports must be identified and available to the individual outside of the program hours and the individual must be capable of seeking them as needed when not receiving HT TAY services.
- The individual's condition must require a structured, integrated program of HT TAY services to develop independent living skills to support the discovery of young adult roles and identities.
- The individual must be engaged in outpatient mental health treatment.
- A comprehensive assessment and individualized plan for each TAY participant will be developed, maintained, and revised accordingly based on changes in individual needs, desires, characteristics, and/or circumstances.
- Family/caregiver participation is encouraged in the establishment, delivery and evaluation of the services provided.

Additional Comments, Considerations or Recommendations:

Please note: Your signature constitutes a referral for services.

Referring Clinician's Signature

Date

Maryland Healthy Transitions (MD-HT)

Priority Population Diagnoses – Adults

SEVERELY MENTALLY ILL PRIORITY POPULATION DEFINITION - ADULTS (SMI)

Revised 9/1/03, 3/10/14, 7/8/14 Reviewed 05/10/07, 1/25/10

Required for MD-HT supports with additional PRP:

INCLUDED DIAGNOSES (DSM-5 – including ICD-9 and ICD-10 diagnosis 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, Current or Most Recent Episode Unspecified
- 296.80/F31.9 Unspecified Bipolar and Related Disorder
- 296.89/F31.81 Bipolar II Disorder
- 301.22/F21 Schizotypal Personality 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 at least 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
- 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.
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.

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Additional Diagnoses that will be considered for MD-HT supports (without additional PRP/RRP):

Major Anxiety Disorders:

300.21-2/F40.0 Agoraphobia

300.02/F41.1 Generalized Anxiety Disorder

300.3/F42 Obsessive Compulsive Disorder

300.01/F41 Panic Disorder

309.81/F43.1 Post Traumatic Stress Disorder

300.23/F40.1 Social Phobia

Exceptions to the diagnostic requirement may be made, on a case by case basis, for youth and young adults who do not have a TAY priority population diagnosis but who do have a history of Residential Treatment Center placement, or a history of multiple psychiatric hospitalizations.

The following Childhood Disorders may be present, but may not be the sole diagnosis: Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, Conduct Disorder, or Learning Disorder.