6910 Annapolis Road
Hyattsville, MD 20784
Telephone: (301) 925-9120
Fax: (301) 851-5199

Safe Journey House
An Ijomah & Associates Company

4607 69th Avenue
Hyattsville, MD 20784
Telephone: (301) 386-0014
Fax: (301) 386-0018

ELIGIBILITY/REFERRAL, SCREENING, AND ADMISSION FORM

COMAR 10.21.26.05

☐ Individual is a participant in the public mental health system (must check yes), COMAR 10.21.26.05A(1)(a)(i).

PART I: BASIC INFORMATION, COMAR 10.21.17.08 B(1)(a-c)

Consumer _____
First Last MI

Sex ☐ Male ☐ Female

SSN _____

DOB _____

Address: _____

City: _____ State: _____

Zip Code: _____ - _____

Consumer Phone Number _____

Sexual Orientation: _____

* Marital Status: ☐ Single ☐ Married ☐ Separated

Employer: _____

Employer Address: _____

Date of Admission, COMAR 10.21.17.08 B(3)**:**_____

Source of Referral, COMAR 10.21.17.08 B(4):

Referred by _____

Credentials _____

Agency name & address _____

_____

_____

Referral Phone Number _____

Race: _____

Emergency Contact/ Relationship: _____ Phone Number: _____
COMAR 10.21.17.08 B(2)

Emergency Contact's Address: _____

PART II: **DIAGNOSIS,** COMAR 10.21.26.05A(1)(ii)

Axis 1: _____ Current GAF ____ Highest GAF in last year ____

_____ has been evaluated by _____ (Physician or Licensed Mental Health Professional) COMAR 10.21.26.05 B(1) and is in need of Crisis Residential Services in order to:

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 10.21.26.04 B(1)(a).

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 10.21.26.04B(2)(a).

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 10.21.26.05 A(1)(a)(iii)
   _____
   _____
   _____

2. What specific factors contributed to the current crisis?
   _____
   _____
   _____

3. Eligibility Checklist (ALL must be checked):

   _____ Has diagnosis that is listed in COMAR 10.09.70.10, COMAR 10.21.26.05A(1)(a)(ii)
   _____ 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 10.21.26.05A(1)(a)(iii)
   _____ Requires separation from living situation due to symptoms of illness, COMAR 10.21.26.05A(1)(a)(iv)
   _____ Willing to comply with all programs rules, COMAR 10.21.26.05A(1)(a)(v)
   _____ Expects, with staff support, to be able to comply with treatment recommendations, COMAR 10.21.26.05A(1)(a)(vi)
   _____ Can and will complete ADL's independently, with staff support, COMAR 10.21.26.05A(1)(a)(vii)

****AN INDIVIDUAL IS NOT ELIGIBLE IF HE/SHE:** (COMAR 10.21.26.05A(2)(a-c)) **(a) has a sole diagnosis of substance abuse, mental retardation, or dementia; (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 _____

Current Symptoms are: ☐ SEVERE ☐ INTENSE ☐ MODERATE

Mental Health Treatment, COMAR 10.21.26.06 A(2)(a):

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

Current Outpatient Providers_____

ELIGIBILITY, REFERRAL, SCREENING, AND ADMISSION FORM

1. Preliminary Plan for the Consumer, to be completed by a Licensed Mental Health Professional, (i.e. substance abuse referral, titration of medication, monitoring of high blood pressure and/or blood sugar, etc.), COMAR 10.21.26.05B(1)(c)**:**

2. Please describe the level and type of staff support required for the Consumer within the first 48 hours of admission, COMAR 10.21.26.05B(1)(c):

3. Which of the following enhanced supports is needed? COMAR 10.21.26.05B(1)(c)

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

PART IV: MEDICATIONS

Substance Abuse, COMAR 10.21.17.08B(8)

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

Last Use Date_____ Frequency of use_____

Physical Health

Current medical conditions: _____

Current monitoring needs (Diabetes, HTN): _____

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

_____

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

Medications, COMAR 10.21.26.05B(1)(b)(ii)

Current Psychotropic Medications

Name	Dosage	Frequency

ELIGIBILITY, REFERRAL, SCREENING, AND ADMISSION FORM

Current Somatic Medications

Name	Dosage	Frequency

VERIFY (Yes/No):

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

Securing Medications for the CRS

Consumer with Medical Assistance (MA)

☐ Prescriptions are filled **OR**

☐ Prescriptions were faxed to _____ pharmacy at _____ am /pm

Consumer with NO Insurance

☐ Arriving with 3 days of medications **OR**

☐ PAC application faxed to Core Services Agency at 301-248-4886 and verified by _____

Physician Signature & Credentials _____ Date _____ COMAR 10.21.17.08 A(1)(b)

Referrer's Signature & Credentials _____ Date _____ COMAR 10.21.17.08 A(1)(b)

Consumer's Signature _____ Date _____

PART V: **AUTHORIZATION**

Insurance Approval (Value Options): 1 - (800) 888-1965; SJH Provider #644290, COMAR 10.21.26.05 A(1)(b)

Medical Assistance # _____ # of Days Authorized _____

Initial Authorization # _____ Dates Approved _____
MM/DD/YY – MM/DD/YY

Extension Authorization # _____ Dates Approved _____
FOR SJH STAFF IF NEEDED MM/DD/YY – MM/DD/YY

Agent Authorizing _____

ELIGIBILITY, REFERRAL AND ADMISSION FORM
SJH STAFF USE ONLY

Staff accepting consumer's entrance to SJH: _____ Date: _____

Consumer assigned to: Consumer Cell Phone Number: _____

☐ 6910 Annapolis Road OR
☐ 4607 69th Ave

1. Complete any section of the form (with the referring party) not already completed.

WHAT HAVE BEEN THE BIGGEST CHALLENGES TO TREATMENT FOR THIS INDIVIDUAL?

_____

_____

2. Verify that ALL the consumer's medication will arrive within 24 hours.

____ Scripts are faxed to CVS/CARE/WAL-MART/OTHER

____ Scripts NEED to be faxed to CVS/CARE/WAL-MART/OTHER

____ PAC application is verified by CSA

____ PAC application NEEDS to be sent to Baltimore for approval

____ Arrived with Medications

3. Somatic conditions: _____

Conditions need to be monitored? ☐ NO ☐ YES

If YES, specify: A) Method_____

B) Frequency_____

4. Verify documentation.

____ Admission/Discharge Summary

____ Psychiatric Evaluation

____ Psychosocial

5. Date of Arrival _____ **Reviewed &Approved by:** _____