

RESIDENTIAL REHABILITATION PROGRAM

APPLICATION FORM INSTRUCTIONS

Residential Rehabilitation Program (RRP) provides housing and supportive services to single individuals. The goal of residential rehabilitation is to provide services that will support an individual to transition to independent housing of their choice. Residential Rehabilitation Programs provide staff support around areas of personal needs such as medication monitoring, independent living skills, symptom management, stress management, relapse prevention planning with linkages to employment, education and/or vocational services, crisis prevention and other services that will help with the individual's recovery.

Please see the enclosed Residential Rehabilitation Program (RRP) application.

- It is **recommended** that the mental health professional and/or mental health provider who works most closely with the applicant complete the application.
- Applicant must sign the RRP Consent For Release of Information Form.
- **Medical Necessity Criteria must indicate why the applicant cannot function independently in the community with other mental health services. There are two levels of care for which an applicant may apply: Intensive or General. The application will not be reviewed by the CSA if the Medical Necessity Criteria is incomplete or has not been met.**
- Priority is given to ***in-county residents***. If the applicant wishes to be referred to another county's RRP, **please state no more than three (3) specific jurisdictions** on the RRP Consent for Release of Information Form.
- If the applicant needs a ***specialty service***, please review the following grid to determine that service:

SERVICE	CSA JURISDICTION
TAY (Transitional Age Youth)	Baltimore City Baltimore County Carroll County Frederick County Howard County Montgomery County Prince George's County (ages 16-24, single parent with no more than 4 children)
DD/MH (Developmental Disability/Mental Health)	Anne Arundel County (accessed through a state hospital) Carroll County Frederick County (include copy of DDA letter stating applicant's eligibility for ISS or SO funding) St. Mary's County
IDDT (Integrated Dual Disorders Treatment)	Frederick County Montgomery County
DEAF AND/OR HARD OF HEARING	Anne Arundel County Baltimore City Baltimore County Frederick County Prince George's County
GERIATRIC	Anne Arundel County Baltimore City Frederick County Prince George's County Wicomico County

- This referral ***does not guarantee*** placement. RRP providers interview eligible applicants as vacancies occur (as directed by the Core Service Agency).
- Questions regarding program vacancies should be directed to the Core Service Agency.
- Please submit only pages 3-10 to the Core Service Agency. Discard pages 1-2 and pages 11-12 (these pages are not necessary and are not required by the Core Service Agency).
- The application must be sent to the Core Service Agency 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). The application can be mailed and/or faxed to the Core Service Agency address (mail) or the Core Service Agency fax number (fax). Please mark the envelope or fax cover sheet: Attn: Adult Services Coordinator or Residential Specialist.

CORE SERVICE AGENCIES:

<p>ALLEGANY COUNTY Allegheny Co. Mental Health System's Office P.O. Box 1745 Cumberland, Maryland 21501-1745 Phone: 301-759-5070 Fax: 301-777-5621</p>	<p>ANNE ARUNDEL COUNTY Anne Arundel County Mental Health Agency 1 Truman Parkway, Suite 101 Annapolis, Maryland 21401 Phone: 410-222-7858 Fax: 410-222-7881</p>
<p>BALTIMORE CITY Behavioral Health System Baltimore One North Charles Street, Suite 1300 Baltimore, Maryland 21201-3718 Phone: 410-637-1900 Fax: 410-637-1911</p>	<p>BALTIMORE COUNTY Bureau of Behavioral Health of Baltimore County Health Department 6401 York Road, Third Floor Baltimore, Maryland 21212 Phone: 410-887-3828 Fax: 410-887-3786</p>
<p>CALVERT COUNTY Calvert County Core Service Agency P.O. Box 980 Prince Frederick, Maryland 20678 Phone: 410-535-5400 #330 Fax: 410-414-8092</p>	<p>CARROLL COUNTY Carroll County Health Department Bureau of Prevention, Wellness, and Recovery 290 South Center Street Westminster, Maryland 21158-0460 Phone: 410-876-4800 Fax: 410-876-4832</p>
<p>CECIL COUNTY Cecil County Core Service Agency 401 Bow Street Elkton, Maryland 21921 Phone: 410-996-5112 Fax: 410-996-5134</p>	<p>CHARLES 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</p>
<p>FREDERICK COUNTY Mental Health Management Agency of Frederick County 22 South Market Street, Suite 8 Frederick, Maryland 21701 Phone: 301-682-6017 Fax: 301-682-6019</p>	<p>GARRETT COUNTY Garrett County Core Service Agency 1025 Memorial Drive Oakland, Maryland 21550-1943 Phone: 301-334-7440 Fax: 301-334-7441</p>
<p>HARFORD COUNTY Office on Mental Health of Harford County 125 N Main Street Bel Air, Maryland 21014 Phone: 410-803-8726 Fax: 410-803-8732</p>	<p>HOWARD COUNTY Howard County Mental Health Authority 8930 Stanford Boulevard Columbia, Maryland 21045 Phone: 410-313-7350 Fax: 410-313-7374</p>
<p>MID-SHORE COUNTIES (Includes Caroline, Dorchester, Kent, Queen Anne and Talbot Counties) Mid-Shore Mental Health Systems, Inc. 28578 Mary's Court, Suite 1 Easton, Maryland 21601 Phone: 410-770-4801 Fax: 410-770-4809</p>	<p>MONTGOMERY COUNTY Department of Health & Human Services Montgomery County Government 401 Hungerford Drive, 1st Floor Rockville, Maryland 20850 Phone: 240-777-1400 Fax: 240-777-1628</p>
<p>PRINCE GEORGE'S COUNTY Prince George's County Health Department Behavioral Health Services Prince George's County Core Service Agency 9314 Piscataway Road Clinton, Maryland 20735 Phone: 301-856-9500 Fax: 301-856-9558</p>	<p>ST. MARY'S COUNTY St. Mary's County Dept. of Aging and Human Services 23115 Leonard Hall Drive, P.O. Box 653 Leonardtown, Maryland 20650 Phone: 301-475-4200 ext. 1682 Fax: 301-475-4000</p>
<p>WASHINGTON COUNTY Washington County Mental Health Authority 339 E. Antietam Street, Suite #5 Hagerstown, Maryland 21740 Phone: 301-739-2490 Fax: 301-739-2250</p>	<p>WICOMICO/SOMERSET COUNTIES Wicomico Behavioral Health Authority/Somerset Core Service Agency 108 East Main Street Salisbury, Maryland 21801 Phone: 410-543-6981 Fax: 410-219-2876</p>
<p>WORCESTER COUNTY Worcester County Core Service Agency P.O. Box 249 Snow Hill, Maryland 21863 Phone: 410-632-3366 Fax: 410-632-0065</p>	

APPLICATION FOR RESIDENTIAL REHABILITATION SERVICES

Date: ___/___/___

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"/> Allegany	<input type="checkbox"/> Calvert	<input type="checkbox"/> Frederick	<input type="checkbox"/> Mid-Shore (Caroline, Dorchester, Kent Queen Anne's, Talbot)	<input type="checkbox"/> Washington
<input type="checkbox"/> Anne Arundel	<input type="checkbox"/> Carroll	<input type="checkbox"/> Garrett	<input type="checkbox"/> Montgomery	<input type="checkbox"/> Wicomico/Somerset
<input type="checkbox"/> Baltimore City	<input type="checkbox"/> Cecil	<input type="checkbox"/> Harford	<input type="checkbox"/> Prince George's	<input type="checkbox"/> Worcester
<input type="checkbox"/> Baltimore County	<input type="checkbox"/> Charles	<input type="checkbox"/> Howard	<input type="checkbox"/> St. Mary's	<input type="checkbox"/> Other: _____

A. 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 Address for Applicant) Please check if address is: <input type="checkbox"/> Shelter <input type="checkbox"/> Temporary housing		Phone Number(s): Home: _____ Mobile: _____ Alternate: _____	
Homeless: <input type="checkbox"/> Yes <input type="checkbox"/> No		Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of Birth: ___/___/___		Age: _____	
Social Security #: ___/___/___			
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender		Race: _____	Marital Status: _____
Sexual Orientation (Optional): _____			
Primary Language: _____		Interpreter Required: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Legal Resident	
Current Entitlements and Income (Fill in amounts and/or insurance numbers)			
Type of Income	Amount of Income (Monthly)	Status of Income (Please check response):	
Supplemental Security Income (SSI)	\$ _____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Pending	
Social Security Disability Insurance (SSDI)	\$ _____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Pending	
Temporary Disability Allowance Program (TDAP)	\$ _____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Pending	
Veteran's Benefit (VA)	\$ _____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Pending	
Employment Earnings	\$ _____	# of Hours Worked: _____	
Other Income: _____	\$ _____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Pending	
NONE (No income/benefit)	<input type="checkbox"/> No income/benefit		
Type of Insurance	Insurance #	Status of Insurance (Please check response):	
Medical Assistance (MA)	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Pending	
Medicare (MC)	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Pending	
Other Insurance: _____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Pending	
NONE (No insurance)	<input type="checkbox"/> No Insurance		
SNAP (Food Stamps) <input type="checkbox"/> Yes <input type="checkbox"/> No		Amount: \$ _____	
Special Needs of Applicant:		Please check your response:	
Does applicant require a 1 st floor and/or ground floor placement in a RRP setting?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does applicant have a functional impairment that affects his/her ability to perform daily functions and/or activities of daily living (ADLs)? <input type="checkbox"/> Yes <input type="checkbox"/> No		Please check if applicable:	
If Yes, please explain: _____		<input type="checkbox"/> Deaf or Hard of Hearing	
_____		<input type="checkbox"/> Blind or Low Vision	
Does applicant require an assistive device?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Assistive device: Any device that is designed, made, or adapted to assist a person to perform a particular task. Examples: canes, crutches, walkers, wheelchairs, shower chairs, etc.		If Yes, please explain: _____	
Does applicant require an adaptive device?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Adaptive device: Any structure, design, instrument, or equipment that enables a person with a disability to function independently. Examples: plate guards, grab bars, transfer boards (also called self-help device).		If Yes, please explain: _____	
_____		_____	

Drug Last Used (including alcohol)	Date(s) Used	Amount	How Used (Smoked, IV, etc.)

Previous Treatment History for Substance Use Disorder(s)	Date(s)
Detox:	
Inpatient Services:	
Outpatient Services:	

Is treatment for the substance use disorder(s) recommended for the applicant? Yes No
Does the applicant agree to treatment for the substance use disorder(s)? Yes No

E. Medications: Please indicate the applicant's ability to take medications. If applicant is prescribed medications, please include one of the following: medication order sheet, medication administration record, or use **Attachment #1: List of Current Medications**.

Independently: <input type="checkbox"/>	With reminders: <input type="checkbox"/>	With daily supervision: <input type="checkbox"/>
Refuses medications: <input type="checkbox"/>	Medications not prescribed: <input type="checkbox"/>	
Please describe your selection for the applicant's ability to take medications. If there is an issue of medication non-compliance, please explain:		

F. Legal Information: This section must be completed by the referral source.

Has the applicant ever been arrested? Yes <input type="checkbox"/> No <input type="checkbox"/>	On Probation or Parole? Yes <input type="checkbox"/> No <input type="checkbox"/>
List current charges:	
List any reported convictions:	
Parole or Probation Officer's Name:	Telephone #:
Has Applicant Been Found NCR (Not Criminally Responsible) by the court/judge? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	Is applicant currently on a Conditional Release Order from the court/judge? Yes <input type="checkbox"/> (Active) Yes <input type="checkbox"/> (Pending) Not Applicable <input type="checkbox"/> Expiration Date of Conditional Release Order: ____ / ____ / ____
Community Forensic Aftercare Program (CFAP): (For applicants who have been adjudicated by the court as Not Criminally Responsible) CFAP Monitor's Name: _____ Telephone #: _____	
Is applicant required to register thru the MD Sex Offender Registry? Yes <input type="checkbox"/> No <input type="checkbox"/> Tier Level of Sex Offense as identified by the MD Sex Offender Registry: Tier 1 <input type="checkbox"/> Tier 2 <input type="checkbox"/> Tier 3 <input type="checkbox"/>	

G. Risk Assessment Information: This section must be completed by the referral source.

Risk Assessment	Never	Past 2+ Years	Past Month-Year	Past Week-Month	Please provide specific details of each item.
Suicide Attempts:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Suicidal Ideation:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Aggressive Behavior/Violence:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fire Setting/Arson:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sexual behavior(s) that are/were non-consensual, injurious, high risk, forcible, Pedophilia, Paraphilia, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Self-injurious behavior or self-mutilation (not suicidal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

H. Previous RRP Experience(s):

Previous RRP Involvement: Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, name of previous RRP provider with dates: _____ If yes, reason for discontinuation of RRP: _____
Consumer Preference of RRP Provider:
Cultural Preference of Consumer:

I. Recommended Level of Residential Placement: Referral source must check recommended level.

<input type="checkbox"/> General Level: Staff is available on-call 24/7 and provides at a minimum, three face-to-face contacts per Individual, per week, or 13 face-to-face contacts per month.
<input type="checkbox"/> Intensive Level: Staff provides services daily on-site in the residence, with a minimum of 40 hours per week, up to 24 hours a day, 7 days a week.
If the applicant requires Intensive 24/7 bed level , please provide specific reasons why the applicant needs additional services beyond the scope of what is provided in the Intensive bed level (<i>Please use Section L on page #8</i>)

J. Medical Necessity Criteria: All applicants must meet Medical Necessity Criteria for a Residential Rehabilitation Program. Please state the applicant's rehabilitation needs below in order to demonstrate Medical Necessity for this service. The specified requirements for severity of need and intensity must be met to satisfy the criteria for admission.

Please state clearly the description for each admission criteria for residential rehabilitation services at the GENERAL Level or the INTENSIVE Level. Unacceptable responses include: Yes, No, Cannot, Maybe, etc.

GENERAL level: Please complete items 1 - 5 of the Admission Criteria

INTENSIVE level: Please complete items 1 - 6 of the Admission Criteria

<u>Admission Criteria</u>	Please write and/or type your response which justifies the specific admission criteria:
1. The consumer has a PBHS specialty mental health diagnosis (Priority Population Diagnosis) which is the cause of significant functional and psychological impairment, and the individual's condition can be expected to be stabilized through the provision of medically necessary supervised residential services in conjunction with medically necessary treatment, rehabilitation, and support.	Priority Population Diagnosis (Primary): _____
2. The individual requires active support to ensure the adequate, effective coping skills necessary to live safely in the community, participate in self-care and treatment, and manage the effects of his/her illness. As a result of the individual's clinical condition (impaired judgment, behavior control, or role functioning) there is significant current risk of one of the following: <ul style="list-style-type: none"> • Hospitalization or other inpatient care as evidenced by the current course of illness or by the past history of the illness • Harm to self or others as a result of the mental illness and as evidenced by the current behavior or past behavior. • Deterioration in functioning in the absence of a supported community-based residence that would lead to the other items 	Previous: List psychiatric hospitalizations including name of the hospital and dates of admission (if known): <div style="border: 1px solid black; height: 80px; width: 100%;"></div> Current: List psychiatric hospitalization including name of the hospital and date of admission (if known): <div style="border: 1px solid black; height: 50px; width: 100%;"></div> Please provide additional information (justification) for #2:
3. The individual's own resources and social support system are not adequate to provide the level of residential support and supervision currently needed as evidenced for example, by one of the following:	Please provide additional information (justification) for #3:

- The individual has no residence and no social support
- The individual has a current residential placement, but the existing placement does not provide sufficiently adequate supervision to ensure safety and ability to participate in treatment; or
- The individual has a current residential placement, but the individual is unable to use the existing residence to ensure safety and ability to participate in treatment, or the relationships are dysfunctional and undermine the stability of treatment

4. Individual is judged to be able to reliably cooperate with the rules and supervision provided and to contract reliably for safety in the supervised residence.

Please provide additional information (justification) for #4:

5. All less intensive levels of treatment have been determined to be unsafe or unsuccessful. Please complete the chart in the right column. ►

<i>Service Type</i>	<i>Provider</i>	<i>Outcome</i>
Case Management		
Outpt. Mental Health Ctr.		
PMHS Provider (private practice/office)		
Psych. Rehab. Program		
Partial Hospital Program		
A.C.T. Mobile Treatment		
Residential Crisis Bed		
Emergency Room		

6. The Individual has a history of at least one of the following:

- Criminal behavior
- Treatment and/or medication non-compliance
- Substance abuse
- Aggressive behavior
- Psychiatric hospitalizations
- Psychosis
- Poor reality testing

AND

Current presentation of at least one of the following behaviors or risk factors that require daily structure and support in order to manage:

- Safety risk
- Active delusions
- Active psychosis
- Poor decision making skills
- Impulsivity
- Inability to perform activities of daily living skills necessary to live in the community
- Impaired judgment (including social boundaries)
- Inability to self-protect in community situations
- Inability to safely self-medicate or self-manage illness
- Aggression
- Inability to access community resources necessary for safety
- Impaired community living skills

Please provide additional information (justification) for #6. DO NOT CIRCLE AND/OR CHECK OFF ANY ITEMS IN #6.

K. Specialized Services: *Please indicate whether or not the specialized service is necessary for the applicant to live in the Residential Rehabilitation Program.*

Specialty Service (Not provided by all RRP providers – See instruction sheet for specific jurisdiction)	Please check your response
ITCOD (Integrated Treatment for Co-Occurring Disorders) - formerly IDDT (Integrated Treatment for Co-Occurring Disorders (ITCOD) model is an evidence-based practice that improves the quality of life for people with co-occurring severe mental illness and substance use disorders by combining substance abuse services with mental health services. It helps people address both disorders at the same time—in the same service organization by the same team of treatment providers.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
TAY (Transitional Age Youth) (“Transition age youth” are defined as individuals between the ages of 16 and 25 years that require comprehensive support services to transition these individuals into adulthood with proper services and supports uniquely tailored to this age group.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
DD/MH (Developmental Disability/Mental Health) (Has a developmental disability as defined by the Developmental Disabilities Assistance and Bill of Rights Act of 2000-Public Law 106-402 and also has a psychiatric disorder as defined by DSM-5)	<input type="checkbox"/> Yes <input type="checkbox"/> No
DEAF (Deaf or Hard of Hearing and/or require the services of American Sign Language interpreters/counselors to assist the consumer to live in the community.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
GERIATRIC (Elderly applicants whose behaviors may be psychiatric in nature that require the services in order to manage the mental illness and the treatment is appropriate to meet their needs. Collaboration and communication with physical medicine and geriatric medicine is necessary for purposes of ongoing management of the behaviors.)	<input type="checkbox"/> Yes <input type="checkbox"/> No

L. Additional Comments: *(Please state additional information that was not specified in the application):*

If applicant requires additional services that are beyond the scope of what is provided in the Intensive RRP bed, please explain what services are needed: _____

Referral Source Name (Please Print): _____

Date Signed: ____ / ____ / ____

Referral Source Signature: _____

**RESIDENTIAL REHABILITATION PROGRAM
CONSENT FOR RELEASE OF INFORMATION**

I, _____, give my consent for _____

(Applicant's Name)

(Core Service Agency)

and any other Core Service Agency checked by the applicant to release this application and other clinical and/or psycho-social history to a Residential Rehabilitation Program for the purpose of assessing my eligibility for residential services in the community. I understand that this information will not be released to another party without my written consent.

I understand this application does not guarantee an interview with a potential Residential Rehabilitation Program and does not commit the Core Service Agency (CSA) to provide a residential placement.

OUT-OF-COUNTY RRP PLACEMENT(S) ONLY:

I give my consent to the Core Service Agency to release my application and/or mental health information to the Core Service Agency (ies) that I have selected below. The applicant is requesting an out-of-county placement for the following reasons: (a) requests to live in a particular jurisdiction; (b) wishes to be near his/her family; (c) the current RRP agencies in the CSA jurisdiction are at capacity and not in a position to expand services; (d) the current RRP agencies in the CSA jurisdiction lack special programming to meet specific needs (for example, TAY, Deaf, etc.). It is understood that the Core Service Agency (ies) will give high priority to its own in-county residents and my application will not supersede an in-county resident (*unless my application was submitted by a state psychiatric hospital provider due to high priority status for placement as mandated by the MD Behavioral Health Administration*). *If the applicant is requesting an out-of-county placement, please select no more than three (3) jurisdictions for submission of the application to the Core Service Agency in the requested county(ies) and the applicant must be willing to live in that jurisdiction.*

<input type="checkbox"/> Allegany	<input type="checkbox"/> Carroll	<input type="checkbox"/> Harford	<input type="checkbox"/> St. Mary's
<input type="checkbox"/> Anne Arundel	<input type="checkbox"/> Cecil	<input type="checkbox"/> Howard	<input type="checkbox"/> Washington
<input type="checkbox"/> Baltimore City	<input type="checkbox"/> Charles	<input type="checkbox"/> Mid-Shore (Caroline, Dorchester, Kent, Queen Anne's, Talbot Counties)	<input type="checkbox"/> Wicomico/Somerset
<input type="checkbox"/> Baltimore County	<input type="checkbox"/> Frederick	<input type="checkbox"/> Montgomery	<input type="checkbox"/> Worcester
<input type="checkbox"/> Calvert	<input type="checkbox"/> Garrett	<input type="checkbox"/> Prince George's	

This consent form will be valid for and will expire in twelve (12) months from my signature date as indicated below. I understand that I will need to submit a new application every twelve (12) months.

(Applicant's Signature)

(Date)

(Print Applicant's Name)

(Witness's Signature)

(Date)

(Print Witness's Name)

If the applicant does not have the legal authority to sign the consent form, the referral source must secure the signature of the person and/or agency representative who currently has the legal authority to provide consent for the submission of the Residential Rehabilitation Program application. Please attach proof of the person's legal authority for the applicant.

Person's Signature: _____

Date: _____

Print Person's Name: _____

Person's Title (if applicable): _____

Person's Telephone #: _____

Agency Name (if applicable): _____

Attachment #2 Priority Population Diagnoses – Adults

Please use the Priority Population Diagnoses listed below as the ***primary diagnosis(es)*** for the applicant.

DSM-5 Diagnosis	ICD-10 CODE
Schizophrenia	F20.9
Schizophreniform Disorder	F20.81
Schizoaffective Disorder, Bipolar Type	F25.0
Schizoaffective Disorder, Depressive Type	F25.1
Other Specified Schizophrenia Spectrum and Other Psychotic Disorder	F28
Unspecified Schizophrenia Spectrum and Other Psychotic Disorder	F29
Delusional Disorder	F22
Major Depressive Disorder, Recurrent Episode, Severe	F33.2
Major Depressive Disorder, Recurrent Episode, With Psychotic Features	F33.3
Bipolar I Disorder, Current or Most Recent Episode, Manic, Severe	F31.13
Bipolar I Disorder, Current or Most Recent Episode, Manic, With Psychotic Features	F31.2
Bipolar I Disorder, Current or Most Recent Episode, Depressed, Severe	F31.4
Bipolar I Disorder, Current or Most Recent Episode, Depressed, With Psychotic Features	F31.5
Bipolar I Disorder, Current or Most Recent Episode, Hypomanic	F31.0
Bipolar I Disorder, Current or Most Recent Episode, Hypomanic, Unspecified	F31.9
Unspecified Bipolar and Related Disorder	F31.9
Bipolar II Disorder	F31.81
Schizotypal Personality Disorder	F21
Borderline Personality Disorder	F60.3
<i><u>The diagnostic criteria may be waived for either one of the following two conditions:</u></i>	
1. An individual committed as not criminally responsible who is conditionally released from a Mental Hygiene facility, according to the provisions of Health General Article, Title 12, Annotated Code of Maryland. <i>Please check if applicable:</i> <input type="checkbox"/>	
2. An individual in a Mental Hygiene facility with a length of stay of more than 6 months who requires RRP services. <i>This excludes individuals eligible for Developmental Disabilities services.</i> <i>Please check if applicable:</i> <input type="checkbox"/>	

Substance Use Disorders

Please use the Substance Use Disorders if the applicant has a co-occurring disorder. This should not be the primary diagnosis. *The primary diagnosis must be one or more of the Priority Population diagnoses listed above.*

Substance Use Disorders	ICD-10 CODE
Alcohol Use Disorder – Mild	F10.10
Alcohol Use Disorder – Moderate	F10.20
Alcohol Use Disorder – Severe	F10.20
Cannabis Use Disorder – Mild	F12.10
Cannabis Use Disorder – Moderate	F12.20
Cannabis Use Disorder – Severe	F12.20
Opioid Use Disorder – Mild	F11.10
Opioid Use Disorder – Moderate	F11.20
Opioid Use Disorder – Severe	F11.20
Stimulant-Related Disorder – Cocaine – Mild	F14.10
Stimulant-Related Disorder – Cocaine – Moderate	F14.20
Stimulant-Related Disorder – Cocaine – Severe	F14.20
Stimulant-Related Disorder – Amphetamine-type substance – Mild	F15.10
Stimulant-Related Disorder – Amphetamine-type substance – Moderate	F15.20
Stimulant-Related Disorder – Amphetamine-type substance – Severe	F15.20
Tobacco Use Disorder – Mild	Z72.0
Tobacco Use Disorder – Moderate	F17.200
Tobacco Use Disorder – Severe	F17.200
Other (or Unknown) Substance Use Disorder – Mild	F19.10
Other (or Unknown) Substance Use Disorder – Moderate	F19.20
Other (or Unknown) Substance Use Disorder – Severe	F10.20