**\*\*\*PLEASE INCLUDE ASSESSMENT AND TREATMENT PLAN WITH FORM\*\*\***

**Please fax to 410 779 9400 or email to** **fccc1@hushmail.com**

|  |  |
| --- | --- |
| Consumer Name: | D.O.B: |
| Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Does the Parent/Guardian have legal custody (if minor)? Yes/ No |
| Address: |
| City: | State: | Zip: |
| Home Phone: | Cell # |
| Medical Assistance #: |
| Race: | Ethnicity: |
| Marital Status: | Gender: |
| Highest Educational Level: | Living Situation: |
| Employment Status: | Veteran -Yes/ No, if yes, DATES AND/OR WARSERVICE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**DIAGNOSIS:**

|  |  |
| --- | --- |
| Axis I |  |
| Diagnosed by |  |

**REFERRAL SOURCE:**

|  |  |
| --- | --- |
| Agency Name | Therapist Name & Credentials  |
| Address: |
| Phone Number: | Fax Number: |
| Email Address: |

**CLINICAL INFORMATION**

|  |
| --- |
| Please include information regarding level of functional impairment: |
| Skills the participant requested to support his/her recovery: |
| Skills to be addressed within the first Individualized Recovery Plan: |
| Participant's identified support systems: |
| Additional Information (Include client request, preference etc) |

**PRP Services Requested (check all that apply)**

|  |  |  |
| --- | --- | --- |
| **ADULT SERVICES ONLY-** Check off services for adult referrals |  |  **YOUTH SERVICES ONLY**- Check off services for youth referrals |
| □ Independent Living Skills | □ Social Skills | □ Adaptive Resources |  | □ Self- Care Skills | □ Social Skills | □ Independent Living Skills |
| □ Medication Management | □ Employment | □ Education/Vocational Training |  | □ Conflict Resolution | □ Anger Management | □ Interpersonal Skills |
| □ Housing | □ Promotion of Wellness | □ Social Relationships/ Leisure Activities |  | □ Age- Appropriate Boundaries | □ Time Management | □ Maintaining personal safety |
| □ Self- Care Skills | □ Crisis Intervention | □ Entitlements Assistance |  | □ Academic Achievement | □ Adaptive Resources | □ Promotion of Wellness |

**Licensed Provider Completing this Application**:

Print Name & Credentials \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_