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

**Please fax to 410 779 9400 or email to** [**fccc1@hushmail.com**](mailto: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 WAR  SERVICE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

**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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_