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
ITCOD (Integrated Treatment for Co-Occurring Disorders)	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:

ALLEGANY COUNTY **Allegany Co. Mental Health System's Office** P.O. Box 1745 Cumberland, Maryland 21501-1745 Phone: 301-759-5070 **Fax: 301-777-5621**	**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**
BALTIMORE CITY **Behavioral Health System Baltimore** One North Charles Street, Suite 1300 Baltimore, Maryland 21201-3718 Phone: 410-637-1900 **Fax: 410-637-1911**	**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**
CALVERT COUNTY **Calvert County Core Service Agency** P.O. Box 980 Prince Frederick, Maryland 20678 Phone: 410-535-5400 #330 **Fax: 410-414-8092**	**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**
CECIL COUNTY **Cecil County Core Service Agency** 401 Bow Street Elkton, Maryland 21921 Phone: 410-996-5112 **Fax: 410-996-5134**	**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**
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**	**GARRETT COUNTY** **Garrett County Core Service Agency** 1025 Memorial Drive Oakland, Maryland 21550-1943 Phone: 301-334-7440 **Fax: 301-334-7441**
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**	**HOWARD COUNTY** **Howard County Mental Health Authority** 8930 Stanford Boulevard Columbia, Maryland 21045 Phone: 410-313-7350 **Fax: 410-313-7374**
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**	**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**
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**	**SOMERSET COUNTY** **Somerset County Core Services Agency** **Somerset County Health Department** 7920 Crisfield Highway Westover, Maryland 21871 Phone: 443-523-1786 **Fax: 410-651-3189**
ST. MARY'S COUNTY **St. Mary's County Local Behavioral Health Authority** **St. Mary's County Health Department** 21580 Peabody Street, P.O. Box 316 Leonardtown, Maryland 20650 Phone: 301-475-4330 **Fax: 301-475-9434**	**WASHINGTON COUNTY** **Washington County Mental Health Authority** 339 E. Antietam Street, Suite #5 Hagerstown, Maryland 21740 Phone: 301-739-2490 **Fax: 301-739-2250**
WICOMICO COUNTY **Wicomico Behavioral Health Authority** 108 East Main Street Salisbury, Maryland 21801 Phone: 410-543-6981 **Fax: 410-219-2876**	**WORCESTER COUNTY** **Worcester County Core Service Agency** P.O. Box 249 Snow Hill, Maryland 21863 Phone: 410-632-3366 **Fax: 410-632-0065**

APPLICANT 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.*

☐ Allegany	☐ Calvert	☐ Frederick	☐ Mid-Shore (Caroline, Dorchester, Kent Queen Anne's, Talbot)	☐ St. Mary's
☐ Anne Arundel	☐ Carroll	☐ Garrett	☐ Montgomery	☐ Washington
☐ Baltimore City	☐ Cecil	☐ Harford	☐ Prince George's	☐ Wicomico
☐ Baltimore County	☐ Charles	☐ Howard	☐ Somerset	☐ Worcester

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: ☐Shelter ☐Temporary housing	Phone Number(s): Home: _____ Mobile: _____ Alternate: _____	
Homeless: ☐ Yes ☐ No	Veteran: ☐ Yes ☐ No	
Date of Birth: ____/____/____ Age: _____	Social Security #: _____/_____/_____	
Gender: ☐ Male ☐ Female ☐ Transgender Sexual Orientation (Optional): _____	Race: _____	Marital Status: _____
Primary Language: _____ Interpreter Required: ☐ Yes ☐ No ☐ U.S. Citizen ☐ 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)	$ _____	☐ Active ☐ Inactive ☐ Pending
Social Security Disability Insurance (SSDI)	$ _____	☐ Active ☐ Inactive ☐ Pending
Temporary Disability Allowance Program (TDAP)	$ _____	☐ Active ☐ Inactive ☐ Pending
Veteran's Benefit (VA)	$ _____	☐ Active ☐ Inactive ☐ Pending
Employment Earnings	$ _____	# of Hours Worked: _____
Other Income: _____	$ _____	☐ Active ☐ Inactive ☐ Pending
NONE (No income/benefit)	☐ **No income\benefit**	
Type of Insurance	Insurance #	Status of Insurance (Please check response):
Medical Assistance (MA)	_____	☐ Active ☐ Inactive ☐ Pending
Medicare (MC)	_____	☐ Active ☐ Inactive ☐ Pending
Other Insurance: _____	_____	☐ Active ☐ Inactive ☐ Pending
NONE (No insurance)	☐ **No Insurance**	
SNAP (Food Stamps) ☐ **Yes** ☐ **No**		Amount: $ _____

Special Needs of Applicant:	Please check your response:
Does applicant require a 1st floor and/or ground floor placement in a RRP setting?	☐ Yes ☐ No
Does applicant have a functional impairment that affects his/her ability to perform daily functions and/or activities of daily living (ADLs)? ☐ Yes ☐ No If Yes, please explain: _____	Please check if applicable: ☐ Deaf or Hard of Hearing ☐ Blind or Low Vision
Does applicant require an assistive device? 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.	☐ Yes ☐ No If **Yes**, please explain: _____
Does applicant require an adaptive device? 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).	☐ Yes ☐ No If **Yes**, please explain: _____

B. Referral Source – Mental Health Professional or Mental Health Provider

Name/Title:	Agency:	Contact Information: Telephone #: ____________ Fax #: ____________ Email: ____________
Psychiatrist Name:	Telephone #:	
Current Providers (Mobile Treatment, Psychiatric Rehabilitation Program, Case Management, Outpatient Mental Health Center, Supported Employment)		
Name of Program	Contact Person	Telephone #
Primary Contact (Examples: Applicant (self), therapist, family member, friend, legal guardian, other)		
Name of Contact:	Telephone #:	Relationship to Applicant:

C. Psychiatric Information: *Please provide the psychiatric and/or substance use disorder of the applicant.*

*(Please see Attachment #**2**: Priority Population Diagnoses \ Substance Use Disorders)*

The Priority Population Diagnosis (es) (PPD) must be present on the first line. Place other diagnoses on the next lines – Substance Use Disorder(s), Medical Disorder(s) (if applicable). Place diagnoses in order of clinical importance.	INTERNATIONAL CLASSIFICATION OF DISEASES (ICD) CODE:
Primary: ____________	____________
Secondary: ____________	____________
____________	____________
____________	____________
____________	____________
____________	____________
____________	____________
____________	____________
Medical Dx: ____________	
____________	
____________	
____________	
Other Conditions that may be a Focus of Clinical Attention:	
____________	____________
____________	____________
____________	____________
____________	____________

D. Substance Use Information:

Substance Use History

Previous history of drug use (including alcohol)	Date(s) Used	Amount	How Used (Smoked, IV, etc.)

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: ☐	With reminders: ☐	With daily supervision: ☐
Refuses medications: ☐	Medications not prescribed: ☐	
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 ☐ No ☐	On Probation or Parole? Yes ☐ No ☐
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 ☐ No ☐ Unknown ☐	Is applicant currently on a Conditional Release Order from the court/judge? Yes ☐ (Active) Yes ☐ (Pending) Not Applicable ☐ 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 ☐ No ☐ Tier Level of Sex Offense as identified by the MD Sex Offender Registry: Tier I ☐ Tier 2 ☐ Tier 3 ☐	

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:	☐	☐	☐	☐	
Suicidal Ideation:	☐	☐	☐	☐	
Aggressive Behavior/Violence:	☐	☐	☐	☐	
Fire Setting/Arson:	☐	☐	☐	☐	
Sexual behavior(s) that are/were non-consensual, injurious, high risk, forcible, Pedophilia, Paraphilia, etc.	☐	☐	☐	☐	
Self-injurious behavior or self-mutilation (not suicidal)	☐	☐	☐	☐	

H. Previous RRP Experience(s):

Previous RRP Involvement: **Yes** ☐ **No** ☐ **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.*

☐ **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.

☐ **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 *(Please use Section L on page #8)*

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

Admission Criteria	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: • 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):* *Current: List psychiatric hospitalization including name of the hospital and date of admission (if known):* *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:*

<table>
<tr><td>

- 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

</td><td></td></tr>
<tr><td>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.</td><td>Please provide additional information (justification) for #4:</td></tr>
<tr><td>5. All less intensive levels of treatment have been determined to be unsafe or unsuccessful.
Please complete the chart in the right column. ►</td><td>
<table>
<tr><th>Service Type</th><th>Provider</th><th>Outcome</th></tr>
<tr><td>Case Management</td><td></td><td></td></tr>
<tr><td>Outpt. Mental Health Ctr.</td><td></td><td></td></tr>
<tr><td>PMHS Provider (private practice/office)</td><td></td><td></td></tr>
<tr><td>Psych. Rehab. Program</td><td></td><td></td></tr>
<tr><td>Partial Hospital Program</td><td></td><td></td></tr>
<tr><td>A.C.T.\Mobile Treatment</td><td></td><td></td></tr>
<tr><td>Residential Crisis Bed</td><td></td><td></td></tr>
<tr><td>Emergency Room</td><td></td><td></td></tr>
</table>
</td></tr>
<tr><td>6. The Individual has a history of at least one of the following:

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

<u>AND</u>
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

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

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) (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 use 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.)	☐ Yes ☐ 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.)	☐ Yes ☐ 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)	☐ Yes ☐ 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.)	☐ Yes ☐ 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.)	☐ Yes ☐ 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. This section can also be used for additional comments about the RRP applicant as needed by the referral source.

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.***

☐ **Allegany**	☐ **Carroll**	☐ **Harford**	☐ **Somerset**
☐ **Anne Arundel**	☐ **Cecil**	☐ **Howard**	☐ **St. Mary's**
☐ **Baltimore City**	☐ **Charles**	☐ **Mid-Shore (Caroline, Dorchester, Kent, Queen Anne's, Talbot Counties)**	☐ **Washington**
☐ **Baltimore County**	☐ **Frederick**	☐ **Montgomery**	☐ **Worcester**
☐ **Calvert**	☐ **Garrett**	☐ **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 #1:

APPLICANT'S NAME: _____ DATE OF BIRTH: _____

LIST OF CURRENT MEDICATIONS

NAME OF MEDICATION	*DOSAGE*	*FREQUENCY*	*ADMINISTRATION (oral, IM, topical)*	*PRESCRIBER'S NAME*

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**

The diagnostic criteria may be waived for either one of the following two conditions:

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.
Please check if applicable: ☐

2. An individual in a Mental Hygiene facility with a length of stay of more than 6 months who requires RRP services. *This excludes individuals eligible for Developmental Disabilities services.*
Please check if applicable: ☐

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**