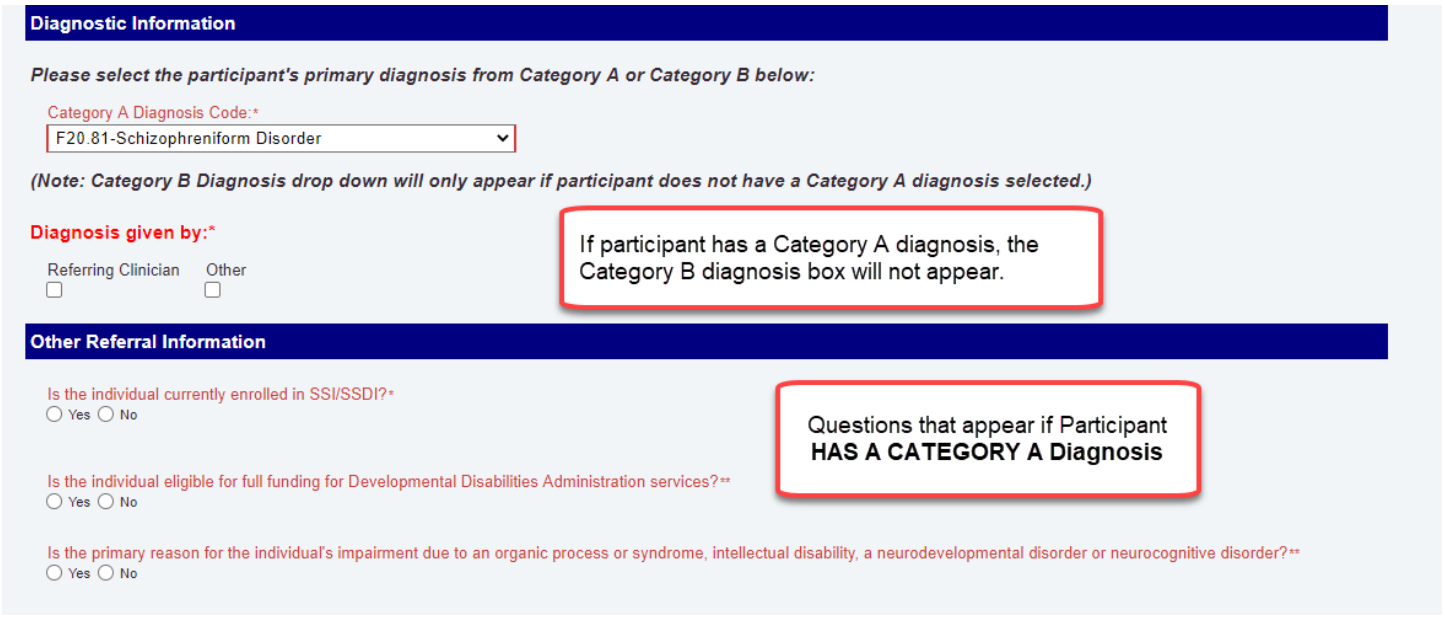
Please note, two different views appear based on Diagnosis selected:

If Category A diagnosis is selected:



If participant does not have a Category A diagnosis, the Category B diagnosis box will appear:

The rest of the form is the same, regardless of diagnosis selected:

Clinical Information

Is individual currently receiving mental health treatment from a licensed mental health professional?**
(•) Yes ( ) No

Name of Treating Licensed Mental Health Professional referring individual to PRP:* Credential* Agency:*

Does this person receive remuneration in any form from the PRP?**
( ) Yes ( ) No

Duration of current episode of treatment provided to this individual**
( ) Less than one month ( ) 2-3 months ( ) 4-6 months ( ) 7-12 months ( ) More than 12 months

Current frequency of treatment provided to this individual:**
( ) At least 1x/week ( ) At least 1x/2 weeks ( ) At least 1x/month ( ) At least 1x/3 months ( ) At least 1x/6 months

Has this individual received PRP services from at least one other PRP within the past year?**
( ) Yes ( ) No

How long has the individual been in PRP services at this agency?**
( ) New referral ( ) Less than 1 year ( ) 1-2 years ( ) 2+ years

This question only appears on Concurrent.

List any additional treating providers:

Name: Credential: Agency:

Name: Credential Agency:

Please indicate which of the following program(s) the individual is also receiving services from:*

Mobile Treatment/Assertive Community Treatment (ACT)**
( ) Not Applicable ( ) Currently ( ) In past 30 days

Inpatient Psychiatric Treatment**
( ) Not Applicable ( ) Currently ( ) In past 30 days

Residential SUD Treatment Service Level 3.3**
( ) Not Applicable ( ) Currently ( ) In past 30 days

Residential SUD Treatment Service Level 3.5**
( ) Not Applicable ( ) Currently ( ) In past 30 days

Residential SUD Treatment Service Level 3.7**
( ) Not Applicable ( ) Currently ( ) In past 30 days

Mental Health Intensive Outpatient Program (IOP)**
( ) Not Applicable ( ) Currently ( ) In past 30 days

Mental Health Partial Hospital Program**
( ) Not Applicable ( ) Currently ( ) In past 30 days

SUD Intensive Outpatient Program (IOP) Level 2.1**
( ) Not Applicable ( ) Currently ( ) In past 30 days

SUD Partial Hospitalization Program (PHP) Level 2.2**
( ) Not Applicable ( ) Currently ( ) In past 30 days

Residential Crisis**
( ) Not Applicable ( ) Currently ( ) In past 30 days

If currently in treatment in one of the services listed above, a written transition plan will be attached to this request.**
( ) Not Applicable ( ) Yes ( ) No

Functional Criteria

Per medical necessity criteria, at least three of the following must have been present on a continuing or intermittent basis over the past two years.

Functional Impairment(s):*

(Check all that apply and list objective evidence in this form, even if other evidence will be attached to this request.)

Marked inability to establish or maintain competitive employment.
☑

Evidence of marked inability to establish or maintain competitive employment:*

Marked inability to perform instrumental activities of daily living (eg: shopping, meal preparation, laundry, basic housekeeping, medication management, transportation, and money management).
☑

Evidence of marked inability to perform instrumental activities of daily living (eg: shopping, meal preparation, laundry, basic housekeeping, medication management, transportation, and money management):*

Marked inability to establish/maintain a personal support system.
☑

Evidence of marked inability to establish/maintain a personal support system:*

Deficiencies of concentration/ persistence/pace leading to failure to complete tasks.
☑

Evidence of deficiencies of concentration/ persistence/pace leading to failure to complete tasks:*

Unable to perform self-care (hygiene, grooming, nutrition, medical care, safety)
☑

Evidence of unable to perform self-care (hygiene, grooming, nutrition, medical care, safety):*

Marked deficiencies in self-direction, shown by inability to plan, initiate, organize and carry out goal directed activities.
☑

Evidence of marked deficiencies in self-direction, shown by inability to plan, initiate, organize and carry out goal directed activities:*

Marked inability to procure financial assistance to support community living.
☑

Evidence of marked inability to procure financial assistance to support community living:*

Duration of Impairment(s):*

Marked functional impairment has been present for less than 2 years.
☐

Marked functional impairment has been limited to less than 3 of the above-listed areas.
☐

Has demonstrated marked impaired functioning primarily due to a mental illness in at least three of the areas listed above at least 2 years.
☐

Has demonstrated impaired role functioning primarily due to a mental illness for at least 3 years.
☐

Alternative Service and Transition Considerations

Consideration has been given to using peer supports and other informal supports such as family.
☐

Functional impairments can be safely addressed at the PRP level of care.
☐

List specific ways in which PRP services are expected to help this individual:*

Confirmation & Attestation

Please note this authorization request is not a guarantee of payment, coverage is still subject to applicable State of Maryland benefits.

I attest all of the information provided is accurate and reflected in the participant's medical record.*
☐

DLA-20 forms will launch automatically when this form is saved. No selection is needed.**
◉ Yes

Important:

1) When this form is saved a pop-up box will appear regarding an additional form being recommended. Click Continue to move to the next form.

2) After the final form is completed you will be returned to the authorization screen.

3) Upload the most recent PRP referral document under Attachments on the authorization screen.

Failure to complete all forms and/or upload required documentation may result in a delay in processing or an administrative denial.