6910 Annapolis Road &
4607 69th Ave
Hyattsville, MD 20784
Telephone: (301) 925-9120
Fax: (301) 851-5199

3050 Old Washington Road
Waldorf, MD 20601
Telephone: (240) 607-9164
Fax: (240) 607-9271

1002 Quince Orchard Road
Gaithersburg, MD 20878
Telephone: (240) 686-6319
Fax: (240) 686-6348

Safe Journey House
An Ijomah & Associates Company

8640 Ridge Road
Ellicott City, MD 21043
Telephone: (410) 461-0760
Fax: (410) 461-0740

ELIGIBILITY/REFERRAL, SCREENING, AND ADMISSION FORM

COMAR 10.63

Individual is a participant in the public mental health system (must check yes), COMAR 10.63.

PART I: BASIC INFORMATION, COMAR 10.63 **Date of Admission,** COMAR 10.63**:**_____

Consumer _____
First Last MI

Source of Referral, COMAR 10.63:

Sex ☐ Male ☐ Female ☐Other

Referred by _____

Race: _____

Agency name & address _____
_____
_____

SSN _____

Referral Phone Number _____

DOB _____

What date will the consumer need a crisis bed? _____

Address: _____

City: _____ State: _____

Zip Code: _____ - _____

Consumer Phone Number _____

Sexual Orientation: _____

Veteran Status Yes No

* Marital Status: ☐ Single ☐ Married ☐ Separated

Is the consumer employed? If so, name of employer: _____

Does the consumer receive SSI or SSDI? Any form of income? YES NO How Much?_____

Medical Assistance # _____

Does the client have Medicare? Yes No If so, Medicare type and #

Emergency Contact/ Relationship: _____ Phone Number: _____
(COMAR 10.63).

Emergency Contact's Address: _____
PART II: **DIAGNOSIS,** COMAR 10.63.

Axis 1: _____ has been evaluated by _____ (Physician or Licensed Mental Health Professional) COMAR 10.63 and is in need of Crisis Residential Services in order to:

ELIGIBILITY, REFERRAL, SCREENING, AND ADMISSION FORM

A _____Inpatient Admission Prevention, which provides services to a consumer who, based on the consumer's history, is evaluated by a physician or mental health professional, has a mental disorder and, without SJH, is at risk for inpatient admission or cannot be discharged from an inpatient facility, COMAR 10.63.

OR

B _____ Inpatient Admission Alternative, which provides services to a consumer who, based on an evaluation by a physician or mental health professional, has a mental disorder**, presents a danger to self or others, and would, without SJH**, be admitted to or could not be discharged from an inpatient facility, COMAR 10.63.

PART III: **DETAIL OF SYMPTOMS**

Please fill out the following questions

1. List current symptoms that lead consumer to being at risk? Please be specific (COMAR 10.63).
   _____
   _____
   _____

2. Eligibility Checklist (ALL must be checked):

   _____ Has a diagnosis that is listed on the Priority Population list (COMAR 10.63)
   _____ Due to acute symptomology related to the individual's psychiatric condition has impaired ability to function within the individual's community living situation and is in need of RCS to avoid inpatient psychiatric admission or to shorten the length of inpatient stay, (COMAR 10.63)
   _____ Requires separation from living situation due to symptoms of illness, (COMAR 10.63)
   _____ Willing to comply with all programs rules, (COMAR 10.63)
   _____ Expects, with staff support, to be able to comply with treatment recommendations, (COMAR 10.63)
   _____ Can and will complete ADL's independently, with staff support, (COMAR 10.63)

****AN INDIVIDUAL IS NOT ELIGIBLE IF HE/SHE:** (COMAR 10.63) **(a) has a sole diagnosis of substance use, major neurocognitive disorder (ex: dementia, intellectual disability); (b) is in need of immediate involuntary inpatient psychiatric admission; or (c) is medically unstable, as determined under the Health Occupations Article, Annotated Code of MD. A consumer cannot be excluded if he/she is homeless.**

Current Suicidal/ Homicidal Ideation: No ___ Yes _____

Current Symptoms are: ☐ SEVERE ☐ INTENSE ☐ MODERATE

Signs of decompensation: _____
_____
_____

Mental Health Treatment, (COMAR 10.63):

Current/Past Hospitalizations: Past Year _____

Current Outpatient Providers_____

ELIGIBILITY, REFERRAL, SCREENING, AND ADMISSION FORM

1. Preliminary Discharge Plan for the Consumer after discharging from Safe Journey House, to be completed by a Licensed Mental Health Professional, (i.e. substance abuse treatment, long term housing, titration of medication, monitoring of high blood pressure and/or blood sugar, etc.), COMAR 10.63**:**

2. Please describe the level and type of staff support required for the Consumer within the first 48 hours of admission, (COMAR 10.63):

3. Which of the following enhanced supports is needed? (COMAR 10.63)

☐ **24 hours on site** ☐ **24 hours on site, awake** ☐ **24 hours, one-to-one**

PART IV: MEDICATIONS

Substance Abuse, (COMAR 10.63)

Currently Abusing: ☐ No or ☐ Yes, which substance? _____

Last Use Date_____ Frequency of use_____

Physical Health

Current medical conditions: _____

Date of consumer's most recent COVID 19 test: _____

Current monitoring needs (Diabetes, HTN): _____

Does the Consumer have a history of, or any current airborne communicable disease (ie Tuberculosis, Legionellosis, Meningococcal disease, and Pneumococcal infections?) ☐ No or ☐ Yes,

_____

Is the consumer medically stable? ☐ N ☐ Y Allergies _____

Is the consumer ambulatory? ☐ N ☐ Y If no, what assistance is needed? _____

Medications, (COMAR 10.63)

Current Psychotropic Medications

Name	Dosage	Frequency

Is the consumer on a long acting injectable? If yes, when was the last injection given? _____

ELIGIBILITY, REFERRAL, SCREENING, AND ADMISSION FORM

Current Somatic Medications

Name	Dosage	Frequency

VERIFY (Yes/No):

____ Lab work (blood levels for consumers on Depakote/ Lithium/Clozaril)

Securing Medications for the CRS

Consumer with Medical Assistance (MA)

☐ Prescriptions are filled and consumer will be arriving with them **OR**

☐ Prescriptions were faxed to _____ pharmacy at _____ am /pm

Consumer with NO Insurance

☐ Please indicate if consumer is arriving with 5, 10, 20, or 30 days of medications **OR**

☐ Medication Assistance to Purchase application faxed to the County's Local Behavioral Health Authority by: _____
What County was application faxed to? _____

Physician Signature & Credentials _____ Date _____ COMAR 10.21.17.08 A(1)(b)

Referrer's Signature & Credentials _____ Date _____ COMAR 10.21.17.08 A(1)(b)

Consumer's Signature _____ Date _____