Hyattsville location
Telephone: (301) 925-9120
Fax: (301) 851-5199

Gaithersburg location
Telephone: (240) 686-6319
Fax: (240) 686-6348

Ellicott City location
Telephone: (410) 461-0760
Fax: (410) 461-0740

Waldorf location
Telephone: (240) 607-9164
Fax: (240) 607-9271

ELIGIBILITY/REFERRAL, SCREENING, AND ADMISSION FORM

Referred by________________________________ Agency Name & Address: ____________________________________

Referral Phone Number: __________________ **What date will the consumer need a crisis bed**? _______________________

PART I: BASIC INFORMATION, COMAR 10.63

Consumer's Full Name ___________________________ DOB_________________________
Sex: ☐ Male ☐ Female ☐Other Race: _________ Full SSN ______________________________________
Address: ______________________________________ City: _______________ State: __________Zip Code: __________
Consumer's Phone Number ________________________ Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Widowed
Is the consumer employed? ☐ Yes ☐ No Insurance: Maryland Medicaid? ☐ Yes ☐ No #____________
Veteran Status: ☐ Yes ☐ No Medicare? ☐ Yes ☐ No Income? ☐ Yes ☐ No
Emergency Contact, Relationship, and Phone Number: ____

PART II: DIAGNOSES, COMAR 10.63: ______________________________________diagnosed by ___________________

PART III: DETAIL OF SYMPTOMS

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

2. What specific factors contributed to the current crisis? (COMAR 10.63)
 ____
 ____

3. Active Suicidal/Homicidal Ideation: No ___ Yes _____

Mental Health Treatment, (COMAR 10.63): Current Mental Health Providers____

1. Preliminary Discharge Plan for the Consumer after discharging from Safe Journey House, 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):

Substance Abuse, (COMAR 10.63) **Currently Abusing: ☐ No or ☐ Yes, which substance? __________________________**

Physical Health (COMAR 10.63)
Current medical conditions: _______________________________ Monitoring needs (ie Diabetes, HTN): ___________
Does the Consumer have any current communicable diseases (ie Tuberculosis, Scabies, COVID-19?) ☐ No ☐ Yes
Is the consumer medically stable? _________ Allergies? ____________ Is the consumer ambulatory?_____________

Authorization (COMAR 10.63) **(Optum): 1-800-888-1965**
☐ Authorization has been obtained for _______ days. Authorization# __________________ Dates approved:____________

Medications
☐ Prescriptions are filled and consumer will be arriving with them ☐ Prescriptions were faxed to __________________

Physician's signature: ____________________________________ Date: ____________________________
Referrer's signature: _____________________________________ Date: ____________________________
Consumer's signature: ____________________________________ Date: ____________________________