8354 Woodland Road, Millersville, MD 21108
8350 Woodland Road, Millersville, MD 21108
1521 Widows Mite, Edgewater, MD 21037
15 Oak Court, Annapolis, MD 21401

Phone: (410)255-3539 Fax: (410)255-8583

Instructions on how to refer to the Residential Crisis Program:

1. Call the Residential Crisis Services program for bed availability.
2. Fill out the referral packet and fax it to Residential Crisis Services (410) 255-8583.

   All referrals must be filled out completely and accurately before approval.

3. Once the referral is reviewed and deemed appropriate, Residential Crisis Services will inform referral source of decision.
4. **A MINIMUM 10-DAY SUPPLY OF ALL SOMATIC AND PSYCHIATRIC MEDICATIONS, (preferred 30 day supply) AND NECESSARY MEDICAL DEVICES/EQUIPMENT MUST ACCOMPANY THE APPLICANT IN ORDER TO BE ACCEPTED INTO RESIDENTIAL CRISIS SERVICES.**
5. **Applicants must have MEDICAID or be UNINSURED.**
6. **Applicants must be able to climb one flight of stairs without assistance.**
7. **Psychiatric or Medical note within 24 hours of discharge.**
8. **Authorization from Optum MD for a 10-day Residential Crisis Bed**
9. **Optum MD 1-800 888 1965**

Referral Packet Consists of the Following:

- Referral
- Program Rules
- Screening Assessment
- Medical Clearance

The following documents are copies of hospital record:

- Mental Status
- Psychiatric history
- Psychosocial Assessment

Harbour House Optum MD Information- UR-Roger Riley, Psychiatrist Dr. Abashidze

Vendor #D351082 Provider #643403

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Residential Crisis Services (RCS)

Date of Application: _____

Name of Applicant: _____ Age: _____ Date of Birth: ___/___/_____

Sex:____ Race:_____ Marital Status: _____ SS#: _____

Address:_____County:_____

City/State/Zip:_____Phone:_____

Psychiatrist:_____Phone:_____

Address: _____City/State/Zip: _____

Therapist: _____Phone:_____

Address: _____City/State/Zip: _____

Referral Source:

Name: _____ Title: _____

Organization: _____ Phone: _____

Address: _____

City/State/Zip: _____

Emergency Contact Information:

Name: _____ Relationship to Applicant: _____

Address: _____ Phone: _____

City/State/Zip: _____

Medical Insurance: **Harbour House can only accept applicants who have MEDICAID or are UNINSURED. If they have private insurance they are ineligible for Residential Crisis Services.**

Medical Assistance/Uninsured: Yes_____No_____ **IF NO, STOP, Harbour House is unable to accept**.

If Uninsured: ID#: _____ If Medicaid: ID#: _____

Optum MD Auth # _____

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Dates: _____ Optum MD Representative: _____

Medicare: Yes_____No_____ If Yes, MEDICARE # _____

Applicant: _____

Eligibility for Residential Crisis Services:

- For Clinical reasons requires a temporary separation from living situation
- Has stated a willingness to comply with rules and treatment recommendations
- Able to care for physical and basic hygiene
- Must have psychiatric diagnosis
- Must be able to self-administer meds.
- **Applicant MUST have MEDICAID or are UNINSURED.**

Reasons for Residential Crisis Services:

- To avert inpatient admission
- To shorten the length of inpatient admission
- To defuse a current crisis
- To evaluate the nature of the crisis
- To stabilize individual to pre-crisis level of functioning
- To link individuals with services in the community.
- Other:_____

Applicant's authorization:

I hereby request Residential Crisis Services (RCS) and understand and am willing to participate in RCS.

_____ _____
Applicant's Name *Date*

_____ _____
Therapist Signature (LCPC or other licensed professional) *Date*

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Applicant: _____

HARBOUR HOUSE PROGRAM RULES

The following rules have been created to ensure the safety of both residents and staff. It is expected that residents and staff will adhere to these rules to provide a therapeutic environment for all while at Harbour House.

1. Residents are to actively participate in the development of their Individual Treatment Plan (ITP) and will actively work on the goals established to the best of their ability.
2. Residents are to take their prescribed medications and report any side effects to the staff so that it can be followed by the psychiatrist.
3. Residents are to administer their own medications while being monitored by staff. Must be able to take care of any somatic needs such as testing blood sugar, using inhaler, etc.
4. Residents may only consume food and drink in designated areas of the house.
5. Residents are responsible for taking care of their own personal care needs but supplies such as toothpaste, tooth brushes, etc. will be supplied by the program.
6. Residents are responsible for cleaning their bedroom and bathroom daily.
7. Residents will perform chores to maintain the residence. Cleaning products will be provided by staff.
8. Residents are to be in their bedrooms between the hours of 10:30 pm and 6 am.
9. Residents and staff will protect the confidentiality of all residents in the program both present and past.
10. Residents may only enter the medication monitoring area one at a time. Staff will indicate when the next resident may enter the area.
11. Residents are to be dressed in street clothes between the hours of 6:00 am and 10:30 pm, and must wear appropriate sleep clothes at bedtime.
12. Residents and staff are to respect the personal boundaries of one another.
13. All cellphones and computers are considered valuable items and will be secured by staff upon admission.
14. Residents may use the Harbour House phone to make calls. Calls are limited to 10 minutes each call but cannot make/take phone calls back to back.
15. Residents may use the Harbour House computer to accomplish tasks related to their treatment plans.
16. A TV schedule will be placed near the set. A resident can sign up to select the show/channel for one hour but may not sign up for consecutive hour slots without the agreement of other residents. Staff will monitor appropriateness of all programs.
17. It is the responsibility of each resident to report to staff any behaviors of others (including staff) that appear to be inappropriate. Management will address any issue raised.
18. Residents are only allowed to smoke during scheduled smoke breaks. Residents are only allowed to smoke cigarettes. All other smoking items prohibited.

Applicant: _____

Residential Crisis Services

Screening Assessment

Diagnosis: Must meet PRIORTY POPULATION – ADULTS

DIAGNOSIS: _____

MEDICAL ISSUES:_____

SOCIAL ISSUES: _____

Current Medications, Frequency and Dosage:

MEDICATION	FREQUENCY	DOSAGE

Recommended Treatment Modalities to be addressed at RCS (Please Check):

- ☐ Assistance with medication monitoring
- ☐ Encouragement to utilize resources
- ☐ Reminders regarding personal hygiene
- ☐ Provide safe and structured environment
- ☐ Assistance with reality testing
- ☐ Confront maladaptive behavior
- ☐ Linkage to community resources
- ☐ Assistance with completion of referral applications
- ☐ Encourage socialization with peers and staff
- ☐ Assistance with developing coping skills
- ☐ Provide reassurance and encouragement to reduce anxiety, anger, fearfulness, etc.
- ☐ Utilize verbal or written contracts for specific problems or behaviors

Other: _____

_____

Applicant: _____

Please check recommended treatment modalities and frequency for follow-up once discharged from RCS.

- ☐ Partial Hospital _____ _____#Days
- ☐ Outpatient Therapy _____ _____x/week
- ☐ Psychiatrist _____ _____x/month
- ☐ Substance Abuse IOP_____ _____x/week
- ☐ AA/NA _____ _____x/week
- ☐ Other support groups_____ _____x/month

Diet:

○ *Normal* ○ *Diabetic Diet* ○ *Low Cal/Restricted Diet (Specify caloric intake)* ○ *Vegetarian*

Food Allergies/other:_____

Level of Care (all care is 24 hour awake):

l. Standard (check one):

a. Staff Supervision with no outside activities

b. Staff supervised outside activities

c. Outings with Case Manager or Agency Provider

ll. Enhanced (check if applicable, if so why?): _____

a. one-on-one contact for first 48 hours

b. extended one-on-one contact

Signature of Mental Health Professional (LCPC, Psychiatrist, Licensed Social Worker) Date

Applicant: _____

Residential Crisis Services

Statement of Medical Clearance

I,_____ certify that_____
(Name of healthcare provider) (Applicant Name)

is medically cleared.

In reviewing the record and/or speaking with the applicant, this applicant appears:

- Good physical health
- Requires physical exam
- Requires follow-up with somatic care

If somatic care follow up is recommended, please provide an explanation: _____
_____
_____

Please list any somatic medications, if any, including frequency and dosage:

**** ALL SOMATIC AND PSYCHIATRIC MEDICATIONS AND NECESSARY MEDICAL DEVICES/EQUIPMENT MUST ACCOMPANY THE APPLICANT, IN ORDER TO BE ACCEPTED INTO RESIDENTIAL CRISIS SERVICES****

_____ _____
Signature of Healthcare Professional Date
(Physician, PA, NP or Psychiatrist)