**Description of Capitation Project Services**

The Capitation Project provides a comprehensive range of coordinated services. Individuals can receive medication management, administration and monitoring; psychiatric evaluation and treatment; individual, group and family therapy; support with daily living skills; entitlements coordination; supported employment; and care coordination.

It is important that applicants understand that:

* They will receive all of their mental health services through the Capitation Project, including psychiatry.
* They will not be able to use their Medical Assistance card to get other mental health services.
* They will need to use their own funds to pay for certain things, including housing.

**Eligibility Criteria (must meet all three):**

1. Be a Baltimore City resident or be willing to reside in Baltimore City;
2. Have a primary diagnosis of a mental illness causing significant impairment in psychosocial functioning, with one of the following diagnoses: Schizophrenia (295.9/F20.9), Schizoaffective Disorder (295.7/F25.0-F25.1), Delusional Disorder (297.1/F22), Major Depressive Disorder (296.33-296.34/F33.2-33.3), Bipolar I & II Disorder (296.43-296.89/F31.13-F31.9), Schizotypal Personality Disorder (301.22/F21), Borderline Personality Disorder (301.83/F60.3); **and**
3. One of the following:
   1. Currently inpatient in a state psychiatric hospital for at least six consecutive months,
   2. Admitted to a psychiatric hospital unit at least four times within the past two years, or
   3. Admitted to an emergency department for treatment of psychiatric condition at least seven times within the past two years.

In addition to these criteria, applicants will be interviewed by the program to determine amenability to the program (i.e., interest in the services offered, ability to engage meaningfully in care, etc.), ability of the program to meet the applicant’s needs in the community, and availability of other needed services.

**Instructions**

Complete all sections of this form, even if attached documentation contains some of the information. Write “N/A” if something is not applicable. Attach the most recent psychosocial assessment, psychiatric evaluation and/or progress notes. Please note that this referral does not guarantee acceptance into Capitation services, and it is recommended that alternative services be explored.

Submit completed referral forms to:

Alicia Torres, Referrals Manager

Phone: 410-637-1900

Fax: 410-637-1911

Email: Alicia.Torres@BHSBaltimore.org

Referral Process:

BHSB will complete the first level of review to ensure that the application is complete and that basic eligibility criteria are met. Once the referral is approved and complete, BHSB will forward it to one of the two Capitation Project provider organizations, which will contact the referral source to set up an appointment to interview the applicant. The Capitation Project provider will work with the applicant and referral source to determine whether the applicant will be accepted into the program.

**Referral Source Information**

|  |  |  |  |
| --- | --- | --- | --- |
| **Contact Name** |  | **Facility/Agency** |  |
| **Phone Number** |  | **Email Address** |  |
| **Psychiatrist’s Name** |  | **Psychiatrist’s Phone** |  |

**Applicant Information**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** |  | **DOB** |  |
| **Gender** |  | **SSN** |  |
| **Race** |  | **Marital Status** |  |
| **Primary Language** |  | **Interpreter needed?** | Yes  No |
| **Address** |  | **Phone Number** |  |
| **Homeless?** | Yes  No | **Veteran?** | Yes  No |
| **Estimated Discharge Date (if inpatient)** |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Other Contacts & Support System** | | | |
| **Name** | **Relationship** | **Phone/Email** | **Emergency Contact?** |
|  |  |  | Yes |
|  |  |  | Yes |
|  |  |  | Yes |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Does the applicant have a guardian?** | | | | |
| No Yes, guardian of person only Yes, guardian of property only Yes, person and property | | | | |
| **If yes, list the guardian’s information below:** | | | | |
| **Name** |  | **Contact Info** |  | Person Property |
| **Name** |  | **Contact Info** |  | Person Property |

**Reason for Referral** (check all that apply *and* provide written explanations below)

|  |  |
| --- | --- |
| Support with daily living skills  Care coordination  Needs help finding housing  Support with adherence to treatment  Decreasing risk of harm to self or others | Support with medication adherence( i.e., monitoring)  Supportive living environment (i.e., assisted living)  Preventing/reducing unnecessary inpatient care  Assistance applying for eligible entitlements/benefits  Help following probation order/conditional release |
| **Describe the applicant’s major needs, including why a lower level of care has/would not meet them:** | |
| **Describe strengths, interests, personal/recovery goals, etc. that are applicable to engagement, recovery/treatment planning, goal development, or success of the applicant:** | |

**Current Income and Entitlements**

|  |  |  |
| --- | --- | --- |
| **Type of Income** | **Status of Income** | **Monthly Amount** |
| **Supplemental Security Income (SSI)** | Active Inactive Pending NA | $ |
| **Social Security Disability Income (SSDI)** | Active Inactive Pending NA | $ |
| **Temp. Disability Allowance Prog. (TDAP)** | Active Inactive Pending NA | $ |
| **Veteran’s Benefit (VA)** | Active Inactive Pending NA | $ |
| **Employment Earnings** | Active Inactive Pending NA | $ |
| **Other:** | Active Inactive Pending NA | $ |
| **Type of Insurance** | **Status of Insurance** | **Insurance #** |
| Medical Assistance (MA) | Active Inactive Pending NA |  |
| Medicare (MC) | Active Inactive Pending NA |  |
| Other Insurance (please list): | Active Inactive Pending NA |  |
| None (no insurance) | Uninsured |  |
| **Other Entitlements/Benefits** | **Status** | **Details** |
| Supplemental Nutrition Assistance Program (SNAP/food stamps) | Active Inactive Pending NA | Amount: $ |
| Section 8 Housing Voucher | Active Inactive Pending NA |  |
|  | Active Inactive Pending NA |  |
|  | Active Inactive Pending NA |  |

**Applicant Psychiatric Information**

|  |  |
| --- | --- |
| **Current Diagnoses\*** | **ICD-10/DMS Code(s)** |
| Primary Behavioral Health Diagnosis: |  |
| Secondary Behavioral Health Diagnoses: |  |
| Medical Diagnoses: | Optional: |
| Other conditions or concerns that may be a focus of clinical attention (e.g., significant trauma, functional challenges, rehabilitation needs, etc.): |  |

*\*Eligible diagnoses include: Schizophrenia (295.9/F20.9), Schizoaffective Disorder (295.7/F25.0-F25.1), Delusional Disorder (297.1/F22), Major Depressive Disorder (296.33-296.34/F33.2-33.3), Bipolar I & II Disorder (296.43-296.89/F31.13-F31.9), Schizotypal Personality Disorder (301.22/F21), Borderline Personality Disorder (301.83/F60.3)*

|  |  |
| --- | --- |
| **Current Medications (psychiatric and somatic)** | **Dosage and Frequency** |
|  |  |

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| --- |
| **Applicant’s ability to take medications as prescribed** |
| Independently With Reminders With Daily Supervision Refuses Medications |
| **Describe your selection. If the applicant does not always adhere to medications, please explain below.** |
|  |

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| --- | --- | --- |
| **Current Mental Status** | | |
| **Orientation** | Person Place Time | |
| **Mood** | Happy Sad Neutral | |
| **Affect** | Euphoric/Manic Mid-Range Dysphoric | |
| **Thought Process** | Organized/Linear Disorganized Illogical Loose Assoc./Flight of Ideas | |
| **Thought Content** | Thoughts focused on: | |
| **Risk Assessment** | | |
| **History of Behavior** | | ***If “yes” is marked, please provide an explanation, including timeframe of last incident (e.g., 2 years ago, 1 week ago, etc.)*** |
| Suicide Attempts | | Yes No Explain: |
| Suicidal Ideation | | Yes No Explain: |
| Aggression/Violence | | Yes No Explain: |
| Homicidal Thoughts | | Yes No Explain: |
| Fire Setting | | Yes No Explain: |
| Treatment Non-Adherence | | Yes No Explain: |
| Impulsivity | | Yes No Explain: |
| Poor Judgement | | Yes No Explain: |
| Problems with Cognition | | Yes No Explain: |
| Lack of Insight | | Yes No Explain: |
| Hallucinations | | Yes No Explain: |
| Delusions | | Yes No Explain: |

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| --- | --- | --- |
| **Most Recent Psychiatric Inpatient Admissions\*** | | |
| **Facility** | **Reason** | **Date(s)** |
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| **Most Recent Psychiatric Emergency Department Visits\*** | | |
| **Facility** | **Reason** | **Date(s)** |
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*\*Applicants must have at least 4 psychiatric inpatient admissions within the past 2 years OR 7 psychiatric emergency department visits within the past 2 years OR an inpatient stay at a state hospital facility for 6+ consecutive months to be eligible.*

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| --- | --- | --- |
| **Current and/or Past Community Mental Health Providers** | | |
| **Provider Organization/Program** | **Level of Care/Type of Service**  **(e.g., ACT, PRP, RRP, OMHC)\*** | **Dates of Enrollment** |
|  |  |  |
|  |  |  |
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*\*Assertive Community Treatment (ACT), Psychiatric Rehabilitation Program (PRP), Residential Rehabilitation Program (RRP), Outpatient Mental Health Center (OMHC)*

**Substance Use History**

|  |  |  |  |
| --- | --- | --- | --- |
| **Substance** | **Use** | **Frequency** | **How Used** (e.g., smoked, IV) |
| Heroin | None Past Present |  |  |
| Cocaine/Crack | None Past Present |  |  |
| Alcohol | None Past Present |  |  |
| Marijuana | None Past Present |  |  |
| Synthetic (K2, Spice, etc.) | None Past Present |  |  |
| Other: | None Past Present |  |  |
| **Is substance use disorder treatment currently recommended?** Yes No | | | |

|  |  |  |
| --- | --- | --- |
| **Current and/or Past Community Substance Use Disorder Treatment Providers** | | |
| **Provider Organization/Program** | **Level of Care/Type of Service**  **(e.g., AA/NA, Detox, Residential)\*** | **Dates of Enrollment** |
|  |  |  |
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**Current Somatic Provider Information (including any specialists)**

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| --- | --- | --- | --- |
| **Current PCP** |  | **Contact Information** |  |
| **Other Provider** |  | **Contact Information** |  |
| **Other Provider** |  | **Contact Information** |  |
| **Other Provider** |  | **Contact Information** |  |

**Legal Information**

|  |  |
| --- | --- |
| **Current Legal Issues** | None Charges Pending On Probation/Parole On Conditional Release Past/Recent Incarceration |
| **Provide Details (specific charges, convictions, etc.)** |  |
| **Monitor/Agent Name** |  |
| **Monitor/Agent Contact Information** |  |
| **Is the applicant required to register through the MD Sex Offender Registry?** | Yes No  Tier I Tier II Tier III |

**For State Hospital Use Only:**

**Is this a pre-screen only?** Yes No

*A “pre-screen” refers to a special screening process for individuals who have been opined Not Criminally Responsible and are being considered for Conditional Release. In these cases, the individual being referred needs to have a provider determine that they would be eligible for Capitation Project services in order to complete the Conditional Release process. Because this process can be lengthy, the Capitation Project provider can decide whether to continue to engage the person. The state hospital should notify the provider once the individual is ready to begin discharge planning.*

**Capitation Project Provider Preference**

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| --- |
| No preference  Chesapeake Connections, Mosaic Community Services  Creative Alternatives, Johns Hopkins Bayview Health System |

**Application Checklist – Referral Source Must Complete**

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| --- |
| All sections are complete. Use NA (not applicable), rather than leaving sections blank.  Release of Information is signed and attached  Most recent progress notes, intake assessments, etc. are attached |

Referral Source Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Release of Information Authorization**

I,            (name), give permission for Behavioral Health System Baltimore to release medical records about my care to either or both of the Capitation Project providers (Chesapeake Connections and/or Creative Alternatives) for the purpose of referring me for mental health care.

This information will not be released to any party other than the above without my express written consent. I understand that I may revoke this consent at any time with a written statement. This consent is valid for 12 months from the date of my signature.

Applicant Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_