**Psychiatric Rehabilitation Services**

**Continuation of Care Form**

Date:

|  |  |  |
| --- | --- | --- |
| Name: | Gender: | Marital Status: |
| SSN: | DOB: | Age: |
| Race: | MA#: | Legal Guardian: |
| Full Address: | Phone #: | Alt. Phone #: |
| Employer/School: | Grade: | Referring Agency: |
| Address: | Contact Person: | Phone #: |
| Email Address: |  |  |

**Functional Impairments**

**PLEASE PROVIDE EVIDENCE OF HOW AT LEAST 3 OF THE CONSUMER’S FUNCTIONAL IMPAIRMENTS ARE RELATED TO THE CONSUMER’S MENTAL HEALTH DIAGNOSIS AND SYMPTOMS. WHAT SYMPTOMS ARE THEY CURRENLY HAVING, AND HOW ARE THESE SYMPTOMS NEGATIVELY AFFECTING THEIR FUNCTIONAL CRITERIA?**

|  |  |
| --- | --- |
| 1. Does the participant have marked inability to establish or maintain competitive employment? |  |
| 2. Does the participant have marked inability to perform instrumental activities of daily living (eg: shopping, meal preparation, laundry, basic housekeeping, medication management, transportation, and money management)? |  |
| 3. Does the participant have marked inability to establish/maintain a personal support system? |  |
| 4. Does the participant have deficiencies of concentration/persistence/pace leading to failure to complete tasks? |  |
| 5. Is the participant unable to perform self-care (hygiene, grooming, nutrition, medical care, safety)? |  |
| 6. Does the participant have marked deficiencies in self-direction, shown by inability to plan, initiate, organize and carry out goal directed activities? |  |
| 7. Does the participant have marked inability to procure financial assistance to support community living? |  |
| 8. Has consideration been given to using peer supports and other informal supports such as family? |  |
| 9. Has participant demonstrated marked functional impairments for at least 2 years? Yes or No. |  |

**PLEASE FILL IN BELOW:**

|  |  |
| --- | --- |
| Last Collaboration Date: | Last Therapy Session Date: |
| Primary Dx: | Secondary Dx: |
| Tertiary Dx: | Dx Given By: |
| Medications: |  |

**CARE AGREEMENT:**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Therapist Name and Title) am consenting to PRP services for my client \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Client Name) and AGS Programs.

Therapist Signature/Credentials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_