**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_