AGS PROGRAMS, LLC
"Achieving Your Greatest Self"
1807 E. Preston Street (Wolfe Street Suite)
Baltimore, MD. 21213
410-276-2123 OR 410-276-2127 (OFFICE) 410-276-4070 (FAX)

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?	

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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:_____