ARMS REACH, LLC
"Every Person is within Arms Reach"
7700 Old Branch Ave. Ste B-104 • Clinton, MD 20735 • 301.877.7748 (Office) • 301.877.7055(fax)

Referral for Services

Date: _____ Services Requested: _____ OMHC _____PRP

Provider Information / Referral Source
Mental Health Professional: _____ Credentials: _____
Agency / Clinic: _____ Supervisor: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Email: _____

Name of client: _____ DOB _____ Age: _____ Sex _____ Race _____
Address: _____ City: _____ State: _____ Zip: _____
MD Medicaid Number: _____ Home Phone: _____
Care Taker (if minor): _____ Relationship: _____
Contact Number: _____ Other Contact Number: _____
Alter. Contact Name: _____ Relationship: _____

REASON/S FOR REFERRAL (describe the behavior/symptoms):

Severe functional impairments in the following domain(s) (check all that applies):

☐ **Home:** _____

☐ **School:** _____

☐ **Community:** _____

☐ **Other:** _____

CLINICAL INFORMATION (If Applicable):

THERAPIST *(if different from person referring)*:
Therapist: _____ Agency: _____
Address: _____
Contact #: _____ Email: _____

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STATEMENT VERIFICATION (If requesting PRP services and receiving OMHC from another agency)

This statement verifies the above individual: (a) is actively receiving outpatient mental health services at our clinic; (b) has severe functioning impairments in at least one or more life domains; and (c) current outpatient treatment will not be sufficient to reduce the individual's symptoms of their functional behavioral impairments. Therefore, PRP is recommended.

_____ _____

(Signature & Credentials of Mental Health Professional) (Name of OMHC Clinic/Agency)

BILLING INFROMATION (For Arms Reach Administration Only)

Medicaid #: _____

Other Insurance / Fee for Service / Uninsured (Circle One)

Other Payment Source: _____

Insurance Company / HMO: _____

Named of Insured: _____