DELAWARE HEALTH AND SOCIAL SERVICES
Division of Substance Abuse and Mental Health

ALCOHOL AND DRUG COMMUNITY SUPPORT PROGRAM

Recertification Form

Part I

Completed by CSP Program

Consumer Name: _____
Last First M.I.

Consumer MCI# _____ (10 digits) D.O.B. ____/____/____ mm dd year

Part II

Physician Recertification (Completed by CSP Physician)
(Due 15 days before current certification period terminates)

CSP Program Name: _____

Admission Date: ____/____/____

Date Current Certification Terminates ____/____/____

Certification Due Date ____/____/____ (15 days before termination)

Based on the indications of the Delaware Assessment Packet completed on ____/____/____ and my examination of ____/____/____ documented in the client record, I hereby certify that the provision of the following community support rehabilitation services _____ , _____ medically necessary for the above named consumer. **(are)** **(are not)**

☐ CTT Level I ☐ CTT Level II ☐ Other

Recertification Effective Date: ____/____/____ End Date: ____/____/____ (1year maximum)

Physician Signature: _____ Date: ____/____/____

Part III

SET/DSAMH Review of Certification (completed by SET/DSAMH)
(Due 15 days after recertification)

The physician's certification and the Delaware Reassessment Packet have been reviewed by the Screening and Evaluation Team/DSAMH and found to be complete.

Agency Authorized Representative Signature: _____ Date: ____/____/____