

DELAWARE DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

DSAMH BEHAVIORAL HEALTH INTENSIVE SERVICE SYSTEM

ELIGIBILITY DETERMINATION REVIEW

ENROLLMENT APPLICATION FORM

DSAMH ELIGIBILITY AND ENROLLMENT UNIT

**Debra Crosson, Director
14 Central Avenue
New Castle, DE 19720**

**302-255-9458 (voice)
302-255-4449 (fax)**

I. DEMOGRAPHIC AND BACKGROUND INFORMATION

1. Applicant's Name: _____
(Last) (First) (M.I.)
2. Date of Application: ____/____/____
3. Applicant Date of Birth: ____/____/____ Gender ___M ___F
4. SS# _____
5. Source and amount of income _____
5. Medicaid #: _____ Medicare # _____
Other insurance (specify) _____
6. Current Residence (type) _____
Indicate whether the applicant lives in a private residence, psychiatric inpatient facility (provide name) or jail/prison (provide name), supervised residence, AMID housing.
7. Current Street Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Work Phone: _____
8. Person to Contact in Case of an Emergency _____
Address _____
Phone Number _____ Relationship _____
- 9.. Primary Language English Spanish American Sign Language Other
10. Race
 American Indian/Alaskan Native AA plus other race/s Black/African American
 BL plus other race/s White/Caucasian CA plus other race/s
 HA plus other race/s Native Hawaiian/other Pacific Islander
 Multiracial Unspecified Asian Asian plus other race/s Unknown
11. Ethnicity
 Puerto Rican Mexican Cuban Other Hispanic Not of Hispanic Origin
 Unknown
12. Name of Employee Submitting the Application:
(Print name) _____
Title: _____ Credentials _____
Signature: _____
Organization: _____
Address: _____

Phone # _____ Fax # _____

13. Current Treatment Provider(s): _____

Community Psychiatrist/Therapist notified of application for services YES ___ NO ___

Do they agree with client's need for intensive services? YES ___ NO ___

Phone # _____ Fax # _____

14. Other agencies working with client _____

15. Family Physician (primary care provider) _____

Phone # _____

16. For Child Mental Health referrals, include the following information:

a. Family contact Name _____

Address _____

City _____ State _____ Zip Code _____

Telephone _____

b. Proposed Living Arrangement at age 18 _____

c. DCMHS Coordinator _____

Phone Number _____

17. Recommended level of care: _____ CCCP _____ Group Home _____ Cornerstone Res.

II. DIAGNOSIS

A. PSYCHIATRIC DIAGNOSIS (DSM-IV-TR)

Diagnosis must have been rendered within the past 12 months.

A copy of the most recent psychiatric evaluation must accompany this application.

For Axes I & II, indicate primary and secondary diagnosis and the justification for the diagnosis

Axis I: Clinical Disorder

Check One (Axis I or II) to indicate PRIMARY DIAGNOSIS

Code _____ [] _____

Code: _____ [] _____

Code: _____ [] _____

Please describe the clinical symptoms and conditions that justify the diagnosis indicated.

Axis II: Personality Disorders/Mental Retardation

Code _____ [] _____

Code: _____ [] _____

Code: _____ [] _____

Please describe the clinical symptoms and conditions that justify the diagnosis indicated.

Axis III: General Medical Conditions (ICD-9-CM name) Use additional space if needed.

Code: _____

Code: _____

Code _____

Code: _____

Code: _____

Please describe the clinical symptoms and conditions that justify the diagnosis indicated.

Axis IV: Psychosocial and Environmental Problems (Check and Describe):

() Problems with primary support group (specify) _____

() Problems related to the social environment (specify) _____

() Educational problems (specify and indicate the highest grade completed) _____

() Occupational problems (specify) _____

() Housing problems (specify) _____

() Economic problems/ management of funds (specify) _____

() Problems with access to health care (specify) _____

() Problems related to interaction with the legal system (specify **all** previous charges, convictions and probationary status) _____

() Other psychosocial and environmental problems (specify) _____

Axis V: Global Assessment of Functioning Scale:

Current: _____ Highest level in the past year: _____

Diagnostician: Psychiatrist who performed the evaluation and formulated the diagnosis:

_____ (Print Name)

Phone # _____ Date of Diagnosis: _____

Signature: _____

Currency of Diagnosis: Diagnosis was rendered within the (check one):

Past Week _____ Past Month _____ Past 90 days _____ Past 180 days _____

Substance Abuse Rule Out

Has a substance abuse diagnosis been specifically ruled out as either a primary or secondary diagnosis?
Yes _____ No _____

If yes, please indicate the basis for the rule out: _____

If a substance abuse diagnosis has **not** been ruled out, a recent Addiction Severity Index (ASI) including the ASAM summary completed or updated by a clinician must be attached to this form. "Recent" is defined as having been completed within the past 90 days.

III. FUNCTIONAL IMPAIRMENT

A. Provide a brief description of the applicant's history with their psychiatric and addictive disorders, including the individual's symptoms, treatment, treatment response and attitude about treatment, emphasizing factors that have contributed to—or inhibited—previous recovery efforts.

1. Mental Illness: _____

2. Substance Abuse (reference ASI findings): _____

3. If the applicant has a co-occurring disorder, describe the interaction between Mental Illness and Substance Abuse: _____

B. Describe the functional impairments that have resulted from the applicant's mental illness and/or substance abuse, including their current manifestation in the following functional domains. Indicate the duration of the impairment, if known to the writer, and reference the Axis IV and Axis V findings from Section I:

1. Self-Care: _____

Duration: Current: __ Recent (within 6 mon.): __ Long Term (6 mon.+): __ Unknown: __

2. Suicidality (distinguish among passive thoughts of being better off dead, ideation with and without a plan, recent attempts, past history of attempts and current potential; provide specific details on the seriousness of attempts): _____

Duration: Current:___ Recent (within 6 mon):___ Long Term (6 mon.):___ Unknown:___

3. Self Control/Impulsivity: _____

Duration: Current:___ Recent (within 6 mon):___ Long Term (6 mon.):___ Unknown:___

4. Dangerousness (distinguish among dangerousness to self, others and property):

Duration: Current:___ Recent (within 6 mon):___ Long Term (6 mon.):___ Unknown:___

5. Caused Community Complaints (bizarre or unusual behaviors) _____

Duration: Current:___ Recent (within 6 mon):___ Long Term (6 mon.):___ Unknown:___

6. Illness Management: _____

Duration: Current:___ Recent (within 6 mon):___ Long Term (6 mon.):___ Unknown:___

7. Emotional Health: _____

Duration: Current:___ Recent (within 6 mon):___ Long Term (6 mon.):___ Unknown:___

8. Interpersonal/Social Functioning: _____

Duration: Current:___ Recent (within 6 mon):___ Long Term (6 mon.):___ Unknown:___

9. Cognition/Learning: _____

Duration: Current:___ Recent (within 6 mon):___ Long Term (6 mon.):___ Unknown:___

10. Motivation/Coping: _____

Duration: Current:___ Recent (within 6 mon):___ Long Term (6 mon.):___ Unknown:___

11. Substance Abuse: _____

Duration: Current:___ Recent (within 6 mon):___ Long Term (6 mon.):___ Unknown:___

12. Physical Health: _____

Duration: Current:___ Recent (within 6 mon):___ Long Term (6 mon.):___ Unknown:___

13. Recovery/Relapse Prevention: _____

Duration: Current:___ Recent (within 6 mon):___ Long Term (6 mon.):___ Unknown:___

IV. SUBSTANTIAL INTERFERENCE WITH OR LIMITATION IN MAJOR LIFE ACTIVITIES

A. Describe the impact of the applicant’s current functional impairments on all affected major life activities:

1. Employment: _____

2. Education: _____

3. Family Relationship: _____

4. Social Relationships: _____

5. Independent Living: _____

V. HISTORY OF INTENSIVE BEHAVIORAL HEALTH TREATMENT

A. Onset of illness and treatment initiation

1. Date of first onset of mental illness	___/___/___	Unknown
2. Date of first treatment for mental illness	___/___/___	_____
3. Date of first onset of substance dependence	___/___/___	_____
4. Date of first treatment for substance dependence	___/___/___	_____

B. Treatment Service history. Include all inpatient and outpatient treatment. We are particularly interested in the past 24 months. If more space is needed, attach additional page(s).

Medication

Dosage

1. _____
2. _____
3. _____
4. _____
5. _____

F. Attach any laboratory tests results, including tests for therapeutic drug levels, alcohol/drug screens, Complete Blood Count (CBC), Complete Metabolic Profile (CMP), Thyroid Stimulating Hormone (TSH) and any other diagnostic studies.

VI. SUMMARY

A. Evaluate the treatment and medication regimens used with the applicant during the last year, indicating reasons for the lack of effectiveness of the treatment plan and/or service delivery.

B. Based on the individual's functional impairments and their effect on major life activities, describe the reasons why traditional out patient treatment cannot meet the applicant's needs and why the applicant requires CCCP Intensive services or Residential Treatment/Support.

C. Has a LOCUS assessment been completed on this client? _____ YES _____ NO

If yes, please attach.



STATE OF DELAWARE
 DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH
AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

In compliance with Federal Regulations (42 U.S.C. 4582 and 21 U.S.C. 1175) and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (45 C.F.R. Pts. 160 and 164)

Client Name: _____ **DOB:** _____
SS#: _____

I, the undersigned, hereby authorize the **Eligibility & Enrollment Unit** to disclose to the following entities:

- **Brandywine Counseling, Inc.**
- **Connections CSP**
- **Corinthian House**
- **Delaware Psychiatric Center**
- **Division of Vocational Rehabilitation**
- **Fellowship Health Resources**
- **Gateway Foundation**
- **Gaudenzia**
- **Horizon House**
- **Kent/Sussex Detox**
- **Kirkwood Detox**
- **Limen House**
- **Psychotherapeutic Services, Inc.**
- **Resources for Human Development**
- **Serenity Place**
- **Tau House**
- **Other:** _____

the following information: **the Eligibility & Enrollment Application Packet, ASI, Assessment Summary, ASAM Summary, Consumer Reporting Forms (pages 1 & 2), Eligibility & Enrollment Summary Sheet and the EEU Service Authorization Form.**

The purpose or need for this disclosure is to coordinate behavioral health care treatment.

I understand that my records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it. I understand that my private health information, once disclosed to others, may be redisclosed to individuals or organizations not subject to HIPAA and may no longer be protected by HIPAA. I understand that generally DSAMH may not condition my treatment on whether I sign an authorization form, but that in certain limited circumstances I may be denied treatment if I do not sign an authorization form.

This consent extends from this date until 60 days post discharge from DSAMH/Contracted services.

Signed _____ **Date** _____

 (Relationship if signed by other than client)