

**DELAWARE DEPARTMENT OF HEALTH AND SOCIAL SERVICES  
DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH  
DSAMH BEHAVIORAL HEALTH LONG TERM CARE SYSTEM  
ELIGIBILITY DETERMINATION REVIEW**

**ENROLLMENT APPLICATION  
FORM**

**DSAMH ELIGIBILITY AND ENROLLMENT UNIT  
Mary Sacre, Interim Director  
NCC Community Mental Health Center  
14 Central Ave.  
New Castle, DE 19720  
302/255-9465 (voice)  
302/255-4448 (fax)  
msacre@state.de.us**

## I. DEMOGRAPHIC AND BACKGROUND INFORMATION

1. Applicant's Name: \_\_\_\_\_  
(Last) (First) (M.I.)
2. Date of Application: \_\_\_\_/\_\_\_\_/\_\_\_\_
3. Date of applicant's enrollment with MCO or current provider : \_\_\_\_/\_\_\_\_/\_\_\_\_
4. SSN: \_\_\_\_\_
5. Medicaid #: \_\_\_\_\_ Medicare # \_\_\_\_\_  
Other insurance (specify) \_\_\_\_\_
6. Current Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_
7. Person to Contact in Case of an Emergency \_\_\_\_\_  
Address \_\_\_\_\_  
Phone Number \_\_\_\_\_ Relationship \_\_\_\_\_
8. Applicant Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ . Gender \_\_\_\_M \_\_\_\_F
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 :**  
\_\_\_\_\_  
Title: \_\_\_\_\_ Credentials: \_\_\_\_\_  
Liaison Signature: \_\_\_\_\_  
Organization: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

13. Current Treatment Provider(s): \_\_\_\_\_  
\_\_\_\_\_  
Phone # \_\_\_\_\_ Fax # \_\_\_\_\_  
Current Community Psychiatrist/Therapist \_\_\_\_\_  
Community Psychiatrist/Therapist notified of application for services YES \_\_\_ NO \_\_\_

14. Other agencies currently working with client \_\_\_\_\_  
\_\_\_\_\_

**15. 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 \_\_\_\_\_

**Copies of the appropriate release of information and patient signed consent forms for submission of enrollment application must be attached to this form.**

**II. DIAGNOSIS**

**A. PSYCHIATRIC DIAGNOSIS (DSM-IV-TR)**

**Diagnosis must have been rendered within the past 12 months.**

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.

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**Axis II: Personality Disorders/Mental Retardation**

Code \_\_\_\_\_ [ ] \_\_\_\_\_

Code: \_\_\_\_\_ [ ] \_\_\_\_\_

Code: \_\_\_\_\_ [ ] \_\_\_\_\_

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

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**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.

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

**Currency of Diagnosis:** Diagnosis was rendered within the (check one): Past Week \_\_\_\_\_  
Past Month \_\_\_\_\_ Past 90 days \_\_\_\_\_ Past 180 days \_\_\_\_\_

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

\_\_\_\_\_ (Print Name)

Phone # \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_

Signature: \_\_\_\_\_

**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.

**B. DRUG AND ALCOHOL DIAGNOSIS.** This section must be completed for applicants whose addictive disorder is primary.

**1. ASI Completion.** A recent ASI completed by a clinician must be attached to this form. "Recent" is defined as having been completed within the past 90 days.

**2. Psychiatric Rule Out.** Has the presence of a co-occurring psychiatric disorder been ruled out? Yes \_\_\_\_ No \_\_\_\_\_. If YES, please indicate the basis for the rule out:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If a psychiatric disorder has not been ruled out, **a recent (within the past 6 months) psychiatric evaluation must be attached to this form.** If the applicant's primary addictions practitioner believes that it is not possible to complete a psychiatric evaluation at this time, please describe the reasons:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ASI Assessor**

Drug/Alcohol Practitioner who completed the ASI: \_\_\_\_\_(name)

Phone Number: \_\_\_\_\_ Date of completion: \_\_\_\_\_

Signature: \_\_\_\_\_

### III. FUNCTIONAL IMPAIRMENT

**A. Provide a brief description of the applicant's history with their psychiatric and/or addictive disorder, including a chronology of the individual's symptoms, treatment, treatment response and attitudes about treatment over time, 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 specific 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. IllnessManagement: \_\_\_\_\_

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. Current and Past Treatment for the Applicant**

Enter the amount of service the applicant has received. "Current" is defined as occurring within the past 12 months. "Past" is defined as occurring within the past 13 to 24 months.

Modality	Current A & D	Current MH	Past A & D	Past MH
Crisis Emergency (face to face)				
Crisis Emergency (calls)				
Inpatient (days)				
Residential (days)				
Detoxification (days)				
Partial Hospitalization (days)				
Day Treatment (days)				
Intensive Outpatient (sessions)				
Intensive Case Management (sessions)				
Continuous Treatment Team (sessions)				
Outpatient (sessions)				
Other Specify:				



**F. Describe, in detail, previous CTT or Group Home placements. Indicate client's response to this level of treatment and any specific problems encountered.**

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**G. Complete the following grid for the applicant's psychotropic medications (current and past); include dosage and length of trial and indicate whether it was therapeutic or sub-therapeutic. Also describe the applicant's response (non-responsive, partial response or full response).**

**Current**

Medication	Dosage	Length of Trial	Therapeutic Trial?	Serum Level (as appropriate)	Applicant's Response
1.					
2.					
3.					
4.					
5.					
6.					
7.					

**Past 12 Months**

Medication	Dosage	Length of Trial	Therapeutic Trial?	Serum Level (as appropriate)	Applicant's Response
1.					
2.					
3.					
4.					
5.					
6.					
7.					

**Psychotropic Medications, Continued**

**Previous 13-24 Months**

Medication	Dosage	Length of Trial	Therapeutic Trial?	Serum Level (as appropriate)	Applicant's Response
1.					
2.					
3.					
4.					
5.					
6.					
7.					

**H. List all currently prescribed non-psychotropic medications; include dosage:**

Medication

Dosage

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**I. List all current over-the-counter medications currently used by the applicant:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**J. List all herbals currently used by the applicant:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**K. List laboratory tests and attach results, including tests for therapeutic drug levels and findings and alcohol/drug screens and abnormal lab values, that have been done in the past six months (specific to psychiatric disorder and/or substance dependence):**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**L. List laboratory tests and attach results for tests done, which are supportive of behavioral health treatment; include Complete Blood Count (CBC), Complete Metabolic Profile (CMP), Thyroid Stimulating Hormone (TSH) and any diagnostic studies.**

**M. Family Physician (Primary Care Provider) \_\_\_\_\_**

## **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.**

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**B. Based on the individual's functional impairments and their effect on major life activities, describe the reasons why the Diamond State Health Plan basic benefit package or other current level of treatment cannot meet the applicant's needs.**

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