

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

ANNUAL RE-DETERMINATION
APPLICATION

DSAMH ELIGIBILITY AND ENROLLMENT UNIT
Ken Donovan, Director
14 Central Ave.
New Castle, DE 19720
302/255-9453 (voice)
302/255-4448 (fax)
Ken.Donovan@state.de.us

I. DEMOGRAPHIC AND BACKGROUND INFORMATION

- 1. Enrollee's Name: _____
(Last) (First) (M.I.)
- 2. Enrollee's MCI #: _____ Date of Birth: ____/____/____
- 3. Current CCCP Provider: _____
- 4. Date of Re-Determination Request: ____/____/____
- 5. Date of enrollee's admission to current provider: ____/____/____
- 6. Current Resident Type:
 - Private Residence – Unsupervised
 - Adult Foster Care
 - Boarding House
 - Other Institutional Setting
 - Homeless
 - Private Residence – Supervised
 - Group Setting - Supervised
 - Group Setting – Unsupervised
 - Nursing Home
 - Other
- 7. Street Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Work Phone: _____
- 8. Medicaid #: _____ Medicare# _____
Other Insurance (Specify) _____
- 9. Does the enrollee have a representative payee? ____ Yes ____ No
If yes, the payee is: _____
- 10. Reason for Re-determination (check all that apply)
Annual RE-certification _____ Change in level of care _____

11. Name of Employee Completing and Submitting the Re-determination Request:

Print Name _____
Signature _____
Title: _____ Credentials¹: _____
Organization: _____
Address: _____
Phone # _____ Fax # _____

¹ According to the CCCP Certification Standards, a Clinician must complete the Comprehensive Medical/Psychosocial Evaluation.

II. DIAGNOSIS

A. PSYCHIATRIC EVALUATION AND DIAGNOSIS (DSM-IV-TR)

Update this section, based on the DSAMH-required annual psychiatric evaluation. Either complete this section or attach a copy of the Psychiatric Evaluation itself. (If attaching the Psych Eval, please ensure that narrative of clinical symptoms and conditions justifying diagnosis is complete)

Diagnosis must have been rendered within the past 30 days.

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

Primary and Secondary 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 (specify) _____

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

() Problems related to interaction with the legal system/crime (specify) _____

() 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: _____

B. 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 addictions assessment completed by a clinician must be attached to this form. The clinician's credentials must meet those specified in the CCCP Certification Standards. "Recent" is defined as having been completed within the past 90 days. If a substance abuse diagnosis has been ruled, please indicate the basis for this:

III. CURRENT CLINICAL NEEDS AND FUNCTIONAL IMPAIRMENT

Describe the enrollee's clinical needs, symptomatology and/or functional impairments that continue to present obstacles to his/her rehabilitation and recovery. The narrative must be personalized for the client being described; do not repeat the pre-printed statements from the LOCUS submission on this client. Describe the client's current clinical profile only; 'current' is defined as the last year. Within the narrative, indicate all significant changes that have occurred during the past twelve months and that impact the client's treatment.

LOCUS Domain 1: Risk of Harm

LOCUS Domain 2: Functional Impairment

LOCUS Domain 3: Medical/Addictive/Psychiatric Co-Morbidity

LOCUS Domain 4: Current Recovery Environment (Level of Stress/Support)

LOCUS Domain 5: Treatment and Recovery History
 (Please address both treatment and recovery specifically)

Please indicate the enrollee's psychiatric hospitalization experience during the past year. Either complete this form or attach your agency's form that provides the same information.

DATES		INPATIENT PROVIDER
FROM	TO	

LOCUS Domain 6: Engagement

IV. REHABILITATION AND RECOVERY PLAN AND PROGRESS

1. CURRENT REHABILITATION AND RECOVERY PLAN (*Treatment and Support*)

a. What does the enrollee describe as his/her personal recovery goals? (If possible, use the client's own words in this answer.)

b. For each of the following domains, briefly describe the rehabilitation/recovery plan and progress made during the past year:

i. Personal Independence (i.e. financial, health management, sobriety)

Recovery Plan: _____

Progress Made: _____

ii. Relationships (i.e. social supports, family)

Recovery Plan: _____

Progress Made: _____

iii. Living Arrangement (i.e. housing situation)

Recovery Plan: _____

Progress Made: _____

iv. Education/Employment/Activity

Recovery Plan: _____

Progress Made: _____

c. Please describe the illness management and recovery strategies that are being taught to the enrollee:

d. Please describe the self-help and peer support components of the rehabilitation and recovery plan:

e. Based on the progress made during the last year, how will the rehabilitation and recovery plan change for the upcoming year:

2. SERVICE UTILIZATION IN RELATIONSHIP TO THE REHABILITATION AND RECOVERY PLAN

a. Please indicate the average number of weekly CCCP contacts made with the enrollee during the past three months (other than medication administration):

___ 3 or more weekly ___ 1 or 2 weekly ___ 1 every two weeks ___ 1 per month

Location of most interactions with the enrollee: ___ at agency ___ in community

Please indicate other behavioral health treatment services the enrollee has received over the past six months

Service	Provider	Frequency

b. Please indicate the average number of weekly CCCP contacts planned to be made with the enrollee during the next three months (other than medication administration):

___ 3 or more weekly ___ 1 or 2 weekly ___ 1 every two weeks ___ 1 per month

Expected location of most interactions with the enrollee: ___ at agency ___ in community

Please indicate other behavioral health treatment services the enrollee will be receiving during the next six months

Service	Provider	Frequency

3. MEDICATION MANAGEMENT

a. Enrollee's current access to Medications

- Medication obtained directly by enrollee (e.g. pharmacy, mail order) and stored at home
- Medication delivered by CCCP
 - Daily
 - Two to Three Times per Week
 - Weekly
 - Every Two Weeks
 - Monthly

b. Describe the plan for medication self-management and the specific steps being taken to achieve it.

V. SUMMARY OF NEEDS AND SERVICE JUSTIFICATION

Please summarize the enrollee's recovery support needs for the next year and explain why CCCP services are required to meet them.

If making a Diagnostic exception to the Eligible Mental Health Diagnosis criteria, please describe the reasons why consumer requires current level of care.
