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

COMMUNITY SUPPORT PROGRAM

Certification Form

Part I

Completed by Screening Agency

Consumer Name: _____
Last First M.I.

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

CSP Provider referred to: _____ Date Referred: ____/____/____

Authorized Agency Representative: _____

Part II

Physician Certification (CSP Program completes 60 days after admission)

CSP Program Name: _____
Admission Date: ____/____/____
Certification Due Date ____/____/____ (60 days later)

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 ☐ Licensed MH Group Home

Medicaid ☐ Yes ☐ No

Certification Effective Date: ____/____/____ End Date: ____/____/____

Physician Signature: _____ Date: ____/____/____

Part III

Screening Agency Review of Certification (completed by CMHC)
(Due 15 days after recertification)

The physician's certification and the Delaware Reassessment Packet have been reviewed by the Community Mental Health Center and found to be complete.

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

Authorized Units: ☐☐☐☐ Authorized Months/Days: ☐☐☐