

DEPARTMENT OF MENTAL HEALTH

CRT ELIGIBILITY DETERMINATION FORM
NEW ENROLLMENT/REENROLLMENT/TRANSFER ENROLLMENT

(Fill out for all enrolling clients – type all information)

NOTE: This form is to be used to report enrollment changes in program assignment and/or change of Designated Agency (DA) for CRT clients. DMH must receive this form from the receiving DA with applicable sections completed, before the transfer enrollment can be completed.

Submission Date

Enrollment Date

Designated Agency:

Type of enrollment

Designated Agency Transferred from:
(if transfer enrollment)

Client Name
(last) (first) (middle initial)

Client Mailing Address

Social Security Number

Date of Birth

Gender

MSR Client ID Number

Insurance/Payer

or Private Insurance

Name of DA staff filling out form Contact

Telephone Number

Signature _____ Date

IMPORTANT: This form is required by DMH and must be completed and submitted for each new enrollee. When complete upload Form to Globalscape. Please email Jessica Whitaker at Jessica.Whitaker@vermont.gov with any questions.

3. Displays maladaptive, dangerous, and impulsive behaviors.

- damages or destroys property
- is self-injurious, expresses suicide threats, or has made suicide attempts
- verbally assaults others, threatens physical violence towards others, or physically harms others
- abuses drugs or alcohol
- creates public disturbances, gets arrested, or has spent time in jail
- requires use of involuntary mental health services.

4. Lacks supportive social systems in the community.

- no close friends or group affiliations
- lives alone
- is highly transient
- has an inability to coexist within family setting or group living situation

5. Requires assistance in basic life and survival skills.

- must be reminded to take medication
- must have transportation to mental health clinic or other supportive services
- needs assistance in household management (budgeting, shopping, meal preparation, etc.)
- is homeless or is at risk of becoming homeless
- inability to access and use community services

Summary of Eligibility

Part A: Diagnosis and GAF criteria met:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Part B: At least 1 criterion met:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Part C: At least 2 criteria met:	<input type="checkbox"/> YES	<input type="checkbox"/> NO

ACTION: Designated Agency check only one:

- Criteria are met. **Enroll in CRT.**
- Criteria are not currently met. **Enroll provisionally in CRT for up to six months.**
- Criteria are not met. **Notify client of appeal rights and refer to other appropriate program(s).**