DEPARTMENT OF MENTAL HEALTH

INTENSIVE HOME AND COMMUNITY-BASED SERVICES INITIAL ELIGIBILITY

☐ **Initial Application** ☐ **Annual Redetermination**

Individual Enrolling in Services

Name: Date of Birth:

Address:

Medicaid Number:

Parent/Legal Guardian ☐ **Yes** ☐ **No** **DCF Custody** ☐ **Yes** ☐ **No**

Name: Telephone Number:

Address:

Name: Telephone Number:

Address:

Designated Agency (DA) Information

Designated Agency Name: DA Case Number:

Case Manager and Contact Information:

Eligibility

Diagnoses

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

Child and Adolescent Needs and Strengths (CANS) Scores (completed within the last 6 months)

1. Emotional/Behavioral (identify 1-2 areas scoring 2 or 3)
2. Life Functioning (identify 1-2 areas scoring 2 or 3)
3. Risk Behavior (identify 1-2 areas scoring 1 or above)

Risk of Institutionalization (include dates of stay/service of previous placements/episodes)

- ☐ Inpatient Hospitalization
- ☐ Hospital Diversion Program or Crisis Program
- ☐ Residential Treatment
- ☐ Emergency Services Intervention
- ☐ Other

Supplemental documents required

- ☐ Consent for enrollment was reviewed with parent/guardian
- ☐ CANS (completed within the last 6 months)
- ☐ Assessment (completed within the last 6 months)
- ☐ Proposed care plan

DMH USE ONLY

Date of Level of Care Determination: Next Review Date:

- ☐ YES, Eligible for IHCBS, acceptance letter and appeals rights sent by _____
- ☐ NO, denial letter and appeals rights sent by _____

SERVICES AUTHORIZED (checkboxes for each service):

- ☐ Case Management
- ☐ Community Skills
- ☐ Psychiatry
- ☐ Individual Therapy
- ☐ Family Therapy
- ☐ Group Therapy
- ☐ Therapeutic Foster Care
- ☐ Staffed Living
- ☐ Respite
- ☐ Other:

DMH Mental Health Care Manager Name and Credentials

Signature