## 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:	cy: 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			
(sign name if form is printed and faxed, otherwise type name if posting to Globalscape)				

<u>IMPORTANT</u>: This form is required by DMH and must be completed and submitted for each new enrollee. Upload Form to Globalscape and email Jessica Whitaker at Jessica.Whitaker@vermont.gov. Call Jessica Whitaker at 802-241-0165 if you have questions.

## **ELIGIBILITY CRITERIA**

- An adult with severe mental illness is defined as a person whose emotional or behavioral
  functioning is impaired so as to interfere with their capacity to function in the community without
  support and treatment.
- The mental impairment is severe and persistent and may result in a limitation of functional capacities for primary activities of daily living, interpersonal relationships, homemaking, self-care, employment, or recreation.
- The mental impairment may limit ability to seek or receive local, state, or federal assistance such as housing, medical and dental care, rehabilitation services, income assistance, food stamps, or protective services. Although persons with primary diagnoses of mental retardation, head injuries, Alzheimer's Disease, or Organic Brain Syndrome frequently have similar problems or limitations, they are not to be included in this definition.

The consumer must have **one of the diagnoses listed below AND** a modified Global Assessment of Functioning (GAF) scale (current functioning) of 50 or below. In addition, the consumer must meet **ONE of Part B and TWO of Part C criteria** in order to be determined eligible for the CRT program by the Designated Agency. If, due to inadequate time to complete assessment or to rule out/in eligible diagnosis **AND** urgent need for services (e.g., involuntary hospitalization or to prevent hospitalization) the criteria threshold is not met, the DA may enroll the individual on a provisional basis for up to six months (or less).

**Diagnostic Criteria -** The diagnosis must be supported by a reliable rating scale. The diagnoses

for CRT Eligibility must meet the ICD-10 criteria for one or more of (check all that apply): Schizophrenia ..... Shizopheniform Disorder ..... Schizoaffective Disorder Delusional Disorder: Unspecified Schizophrenia Spectrum and other Psychotic Disorder Major Depressive Disorder Bipolar I Disorder..... Bipolar II Disorder, Other specified Bipolar and related Disorder. Panic Disorder Agoraphobia Hoarding Disorder, Obsessive-Compulsive Disorder, Other specified Obsessive-Compulsive and Related Disorder, Unspecified Obsessive-Compulsive and Related Disorder ...... Borderline Personality Disorder ..... ICD-10 - Diagnostic Code (Please indicate all diagnoses contributing clinical complexity to or cooccurring with CRT eligible diagnoses.)

ICD 10 Tertiary:

ICD 10 Quaternary:

ICD 10 Primary:

ICD 10 Secondary:

A.4.	GAF (current).	Score	Date
	GAF (highest in past year):	Score	Date
	Is the functional impairment rela	nosis reported in A1?  Yes  No	
	Date of Diagnosis		
	Diagnostician		
В.	more episodes of inpatier	chiatric treatment psychiatric to	cent with a duration of at least sixty days, or three or reatment, or community-based hospital elve months. (Check if one or more applies.)
		partial hospita	pitalization with a duration of at least sixty days, or dization or day treatment during the last twelve
			hree or more episodes of residence in one or more nonths: ( <i>Check all that apply.</i> )
	<ul><li>☐ Residential Program</li><li>☐ Community Care Hor</li><li>☐ Living situation with</li></ul>		oviding primary supervision and care
	4. Participation in an output during the last twelve mo		alth treatment modality for a six-month period evidence of improvement.
	5. The individual is on a cou	art Order of No	on-Hospitalization.
C.	Impaired Role Functioning (months, supported by corrobor	-	twelve months, for a duration of at least six
	1. A serious impairment in	n social, occupa	ational, or self-care skills. (Check all that apply.)
	significant withdrawa consistent failure to n	l and avoidanc naintain person	disrupted relations with others e of almost all social interaction al hygiene and appearance and self-care d standards in school, work, or parenting
	2. Receives public financial	assistance bec	ause of a mental illness.
	□SSI □SSDI □VA	□ Other	

3.	Displays maladaptive, dangerous, and impulsive behaviors.
	<ul> <li>damages or destroys property</li> <li>is self-injurious, expresses suicide threats, or has made suicide attempts</li> <li>verbally assaults others, threatens physical violence towards others, or physically harms others</li> <li>abuses drugs or alcohol</li> <li>creates public disturbances, gets arrested, or has spent time in jail</li> <li>requires use of involuntary mental health services.</li> </ul>
4.	Lacks supportive social systems in the community.
	<ul> <li>□ no close friends or group affiliations</li> <li>□ lives alone</li> <li>□ is highly transient</li> <li>□ has an inability to coexist within family setting or group living situation</li> </ul>
5.	Requires assistance in basic life and survival skills.
	<ul> <li>must be reminded to take medication</li> <li>must have transportation to mental health clinic or other supportive services</li> <li>needs assistance in household management (budgeting, shopping, meal preparation, etc.)</li> <li>is homeless or is at risk of becoming homeless</li> <li>inability to access and use community services</li> </ul>
Summa	ary of Eligibility
Part B:	osis and GAF criteria met:  At least 1 criterion met:  At least 2 criteria met:  YES  NO  YES  NO  NO
ACTION: De	signated Agency check only one:
Criter	ia are met. Enroll in CRT. ia are not currently met. Enroll provisionally in CRT for up to six months. ia are not met. Notify client of appeal rights and refer to other appropriate (s).