DEPARTMENT OF MENTAL HEALTH

INTENSIVE HOME AND COMMUNITY-BASED SERVICES INITIAL ELIGIBILITY

	Initial Application		Annual Redetermination		rmination
Individual Enrolling in Se	rvices				
Name:			Date of Birth:		
Address:					
Medicaid Number:					
Parent/Legal Guardian	Yes	No	DCF Custody	Yes	No
Name:		Teleph	none Number:		
Address:					
Name:		Teleph	none Number:		
Address:					
Designated Agency (DA)	Informati	on			
Designated Agency Name	<u>)</u> :		DA Case	Number	:
Case Manager and Conta	ct Informa	ntion:			
Eligibility					
Diagnoses					
1.			_ 4.		
2			5.		
			_ 3.		
3			6.		
Child and Adolescent Ne	eds and S	trengths (C/	ANS) Scores (comp	oleted wi	thin the last 6 months)
 Emotional/Behavareas scoring 2 o 	· ·	ntify 1-2	2.	Life Fund scoring 2	ctioning (identify 1-2 areas ? or 3)
3. Risk Behavior (ide	entify 1-2	areas scorin	ng		

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

DMH Mental Health Care Manager Name and Credentials

Signature

Staffed Living

Respite Other: