**Section 17**

**Community Support Services Clinical Eligibility Determination Form**

**Client Information:**  **Diagnostic Information:**

Name: Click or tap here to enter text. Diagnosing Clinician: Click or tap here to enter text.

DOB: Click or tap here to enter text. Primary Diagnosis:\* Click or tap here to enter text.

Date of Diagnosis: Click or tap to enter a date.

\* **If the primary diagnosis is Schizophrenia or Schizoaffective disorder, do not fill out numbers 1 and 2 below**. Any primary diagnosis in accordance with the DSM V may qualify if combined with a LOCUS score of 17 or greater, **with the exclusion** of: Neurocognitive Disorders, Neurodevelopmental Disorders, Substance Use Disorders, or Antisocial Personality Disorder.

**The client** *(check all that apply)***:**

1. **Client History:**
2. Has received treatment in a state psychiatric hospital within the past 24 months

(NOTE: Dates of admission are available in Atrezzo; supporting documentation not required),

1. Has been discharged from a mental health residential facility within the past 24 months

(NOTE: Dates of discharge are available in Atrezzo; supporting documentation not required),

1. Has had two or more episodes of inpatient treatment for mental illness, for greater than 72 hours per episode,

within the past 24 months,

1. Has been committed by a civil court for psychiatric treatment as an adult,
2. Was eligible as a child under age 21 with severe emotional disturbance AND currently has risk factors for

requiring mental health inpatient treatment or residential treatment.

**OR;**

1. **As stated in documented or reported history (may include oral or written history from the client, a provider, or a caregiver), is likely to have future episodes related to a mental illness with a non-excluded DSM V diagnosis that, without Community Support services, would result in or result in significant risk of (check all that apply):**
2. Homelessness,
3. Mental health residential treatment,
4. Mental health inpatient stay greater than 72 hours,
5. Criminal Justice involvement.

**A Section 17 qualified Clinician2 must either attach documentation supporting criterion #1.c, #1d, or #1.e, or provide clinical justification below based on direct interaction with the member to support criterion #2:**

**Signatures and Certifications:**

I, , certify and attest I rendered the clinical opinion

***Clinician Signature***

above based on a direct interaction with the member (required for #2) and/or a review of history in accordance with the Specific Requirements of Section 17.02-3 of the MaineCare Benefits Manual. This clinical opinion is true and complete to the best of my knowledge and belief.

Print Name and Credentials

Date: