**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: