

CERTIFICATION OF ELIGIBILITY FOR BEHAVIORAL HEALTH OVERLAY SERVICES – CHILD WELFARE

Date: _____

This is to certify that:

Child's Name _____ Date _____

Medicaid Number _____

has been screened and meets the following clinical eligibility criteria to receive Behavioral Health Overlay Services – Child Welfare.

The child or adolescent is placed in: _____,
(Name of provider and site)

a Medicaid enrolled residential program that has been certified (or self-certified) to provide behavioral health overlay services and meets the clinical criteria as listed below.

The child or adolescent meets the diagnostic eligibility criteria described in Section A and one of the five risk factors in Section B.

Section A:

- The child has an ICD-9-CM diagnosis in the following range: 294.8, 295.0 through 298.9, 300 through 301.9, 307.1, 307.23, 307.5 through 307.7, 308.0 through 312.4, 312.81 through 314.9; And 303.0 through 305.9

AND

- The child demonstrates significant impairment of age-appropriate, developmental progression or psychosocial functioning due to the ICD-9-CM psychiatric disorder, in one or more of the following areas: family, social and peer relationships, educational or vocational.

AND

Section B: Risk Factors. The recipient is at risk due to one of the following and such risk is documented and detailed. Please attach relevant documentation to this form.

- (1) A history of suicidal gesture, attempt or self-injurious behavior or current ideation related to suicidal or self-injurious behavior, though not currently in need of acute care;
- (2) A history of physical aggression or violent behavior toward persons, animals or property. This risk may also be evidenced by current threats of such aggression;
- (3) A history of running away from home or placements or current verbal threats to run away on one or more occasions;
- (4) A history or recent occurrences of sexual aggression or victimization;
- (5) A history of criminal or delinquent behavior.
- (6) A history of or current psycho-active chemical use
- (7) A history of disrupted out-of-home placements; or
- (8) Has recently been removed from home because of abuse or neglect and placed in a group shelter setting.

Certified by:

Counselor _____ Date _____

Licensed Practitioner _____ Date _____

Services will be reviewed and re-certified prior to: _____
(six months from the date of original certification)

This form is to be placed in recipient's (child's) medical record.