CERTIFICATION OF ELIGIBILITY FOR BEHAVIORAL HEALTH OVERLAY SERVICES – DEPARTMENT OF JUVENILE JUSTICE

This is to certify that:

Date: ____________________

Child's Name: ____ Medicaid No: ____________________

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

The child or adolescent is placed in: ____
(Name of provider/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, 1 or 2, and one of the four risk factors in Section B.

Section A: Diagnostic Criteria. The child or adolescent:

1. Has an ICD-9-CM diagnosis of 295.0 through 298.9 (psychotic disorder, major depression or bipolar disorder);

   ____
   (Specify diagnosis)

   OR

2. Has an ICD-9-CM diagnosis in the following range: 294.8, 294.9, 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 ;

   ____
   (Specify diagnosis)

   AND

   Has been enrolled in a special education program for the seriously emotionally disturbed or emotionally handicapped;

   ____
   (Specify type of program)

   OR

   Has scored a 60 or below on the Axis V Global Assessment of Functioning Scale, or Child's Global Assessment Scale, within the last 6 months and the justification for such a score is well documented and detailed on the certification form.

   ____
   (Scale/Score)

continued

APPENDIX I, continued

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Section B: Risk Factors. The recipient is at risk due to one of the following (check one) and such risk is documented and detailed on the back of this eligibility certification form:

☐ (1) Has 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;

OR

☐ (2) Has 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;

OR

☐ (3) Has a history of running away from home or placements or current verbal threats to run away on one or more occasions;

OR

☐ (4) Has a history, or recent occurrences of, sexual aggression or victimization.

Certified by:

____ ____________________
Counselor Date

____ ____________________
Licensed Practitioner Date

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

To be placed in recipient's (child's) medical record.