APPENDIX K
ADULT CERTIFICATION
INTENSIVE CASE MANAGEMENT TEAM SERVICES
ADULT MENTAL HEALTH TARGETED CASE MANAGEMENT

Recipient's Name: ____________________________ Medicaid ID #: __________________

Is hereby certified as meeting all the following Intensive Care Management criteria.

1. Is enrolled in a Department of Children and Families adult mental health target population.

2. Meets at least one of the following requirements (check all that apply):
   a. Has resided in a state mental health hospital for at least six months in the past 36 months. List the facilities and dates of admission and discharge:

   ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________

   b. Resides in the community and has had two or more admissions to a state mental health hospital in the past 36 months. List the state facility and dates of admission:

   ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________

   c. Resides in the community and has had three or more admissions to a crisis stabilization unit (CSU), short-term residential facility (SRT) or inpatient psychiatric unit, or any combination of these facilities within the past 12 months. List the facilities and dates of admissions and discharges:

   ____________________________________________
   ____________________________________________
   ____________________________________________

Appendix K, continued

d. Resides in the community and, due to a mental illness, exhibits or would exhibit behavior or symptomatology that could result in long term hospitalization if frequent interventions for an extended period of were not provided. Explain:

__________________________________________________________

__________________________________________________________

3. Has relocated from a Department of Children and Families district where he or she was receiving intensive case management team services.

Case Manager  

Date

Case Manager’s Supervisor  

Date

Form must be filed in the recipient’s case record.