CERTIFICATION OF ELIGIBILITY

This is to certify that:

Date: _______________

Recipient's Name: ____________________________________ Medicaid No: ________________________

has been screened and meets the following clinical eligibility criteria to receive behavioral health overlay services.

Recipient 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 recipient meets the eligibility criterion described in Section A and one of the five risk factors in Section B.

Section A: Diagnostic Criterion. The recipient is:

❑ Under the age of 21 years and has an emotional disturbance or a serious emotional disturbance.

____
(Specify diagnosis)

Section B: Risk Factors. The recipient is at risk due to one of the following in the last 12 months and such risk is documented and detailed (check one). Please attach relevant documentation to this certification.

❑ (1) Has exhibited suicidal gestures or attempts, or self-injurious behavior or current ideation related to suicidal or self-injurious behavior, and is not in need of acute care.

❑ (2) Has exhibited physical aggression or violent behavior toward persons, animals or property. This risk may also be evidenced by current threats of such aggression.

❑ (3) Has run away from home or placements or threatened to run away on one or more occasions.

❑ (4) Has had an occurrence of sexual aggression.

❑ (5) Has experienced trauma.

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 clinical record.

AHCA Form 5000-3522, Revised March 2014 (incorporated by reference in Rule 59G-4.027, F.A.C.)