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.

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_____ 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:

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_____ 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:

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AHCA-Med Serv Form 031, July 2006 (incorporated by reference in 59G-4.199, F.A.C.)

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:

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____ 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.

AHCA-Med Serv Form 031, July 2006 (incorporated by reference in 59G-4.199, F.A.C.)