Form OMH 143a (MH) (6-91)

State of New York
OFFICE OF MENTAL HEALTH

Community Support Services
ELIGIBILITY DETERMINATION

1. Facility Name | Facility Code | 2. Unit Name | Unit Code

3. Client Name PRINT (Last) (First) (M.I.) | 4. Social Security Number

5. Address (Number) (Street) | 6. NYS ID Number

(City) (State) | 5a. Zip Code | 7. Date of Birth (MO. DAY YEAR) | 8. Sex ☐ Male ☐ Female

9. **Most Recent Diagnosis** (Principal diagnosis must be psychiatric. *Use DSM III-R and specify codes as well as diagnoses).*
A. Principal Diagnosis — DIAGNOSTIC CODE
B. Other Diagnosis — DIAGNOSTIC CODE

10. **Functional Disability**
A. Client is functionally disabled due to mental illness, and without provision of community support services the client's ability to remain in the community would be seriously jeopardized:
☐ YES ☐ NO

B. Client is functionally disabled in the areas indicated *(Check all that apply; three areas are needed to establish eligibility for CSS):*
☐ Self Care ☐ Activities of Daily Living ☐ Self Direction
☐ Social Functioning ☐ Economic Self Sufficiency ☐ Ability to Concentrate

11. The client is eighteen years of age or older, functionally disabled due to mental illness, has a principal psychiatric diagnosis, and:
☐ A. Meets the permanent eligibility criteria (complete item 12 below).
☐ B. Meets the categorical eligibility criteria (complete items 13 and 14 below).
☐ C. Waiver is requested (complete item 15 below).

12. **Permanent Eligibility** *(Check all which apply):*
☐ A. One six month stay in an inpatient psychiatric unit.
☐ B. Two stays of any length in an inpatient psychiatric unit in the preceding two years.
☐ C. Client is Chapter 620/621 Eligible.
☐ D. Three or more admissions to an Office of Mental Health operated or licensed mental health outpatient program or a forensic satellite unit operated by the Office of Mental Health within the preceding 18 months; or three or more contacts with crisis or emergency mental health services within the preceding 18 months; or a combination of three admissions or contacts within the preceding 18 months.
☐ E. SSI/SSD recipient due to mental illness.
☐ F. Twelve months active enrollment as a waived client.
☐ G. Six months consecutive residency in a designated adult home.
☐ H. Six months consecutive residency in a community residence.
☐ I. Six months consecutive residency in a Residential Care Center for Adults (RCCA).
☐ J. Six months consecutive residency in a family care home.
☐ K. Six months consecutive residency in a Residential Treatment Facility (RTF).

13. **Categorical Eligibility**
☐ A. Resident in a designated adult home, less than six months.
☐ B. Resident in a designated shelter for the homeless.
☐ C. Resident in a designated single room occupancy hotel (SRO).
☐ D. Resident in a community residence, less than six months.
☐ E. Resident in a family care home, less than six months.
☐ F. Resident in a Residential Care Center for Adults (RCCA), less than six months.
☐ G. Inpatient in a state-operated psychiatric facility and scheduled for placement within ninety days to a community residence, Residential Care Center for Adults (RCCA), or Family Care.

14. **Initial Date of Residency** (MO. DAY YEAR)

15. **Waiver Request**

A. Waiver Requested by: | Name (Last) (First) (M.I.) PRINT | Title

B. Local Government Action: ☐ 1. Approved ☐ 2. Disapproved | Name (Last) (First) (M.I.) PRINT | Title

(MO. DAY YEAR)

16. **Certification:** I certify that this client, who is eighteen years of age or older, functionally disabled due to mental illness, and whose ability to remain in the community would be seriously jeopardized without the provision of community support services, meets the permanent or categorical eligibility requirements or a request has been submitted to waive such criteria.

Signature | Name signed (Print)

Title | Today's Date (MO. DAY YEAR)

Distribution: White—Patient Record • Yellow—Local Government/Core Services Agency