Client Name: _____ CMBHS #: _____

## Yes Waiver Clinical Eligibility

* Eligibility Type *

Notes on Eligibility Type
(Required when Eligibility is Termination)

* Start Date *

* End Date *

* Has Individual lived in a facility during the last 12 months (i.e RTC,State School,Group Home)?
If yes please provide Facility details

* ◯ Yes ◯ No

This information is populated from the client's diagnosis

| Order | Code | Descriptor |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |

Minimum search 3 chars Code/ 5 chars Descriptor

**Note:** Principle Diagnosis in this Episode of Care is line 1 in the Order of Treatment Services.

**Comments**

## CANS Assessment Criteria

This information is populated from the client's CANS

CANS Assessment Date

Criteria A

| Child and Adolescent Needs and Strengths(CANS) Domain | Domain Score |
|---|---|
| Life Domain Functioning Domain | |
| Developmental Needs: Cognitive | |
| Developmental Needs: Developmental | |

Criteria B

| Child and Adolescent Needs and Strengths(CANS) Domain | Domain Score | Child and Adolescent Needs and Strengths(CANS) Domain | Domain Score |
|---|---|---|---|
| Child Risk Behaviors: Suicide Risk | | Caregiver Strengths and Needs: Involvement with Care | |
| Child Risk Behaviors: Self Mutilation | | Caregiver Strengths and Needs: Family Stress | |
| Child Risk Behaviors: Other Self Harm | | Caregiver Strengths and Needs: Safety | |
| Child Risk Behaviors: Danger to Others | | Life Domain Functioning: School | |
| Child Risk Behaviors: Sexual Aggression | | Life Domain Functioning School Module – School Behavior | |
| Child Risk Behaviors: Fire Setting | | Life Domain Functioning School Module – Attendance | |
| Child Risk Behaviors: Delinquency | | Psychiatric Hospitalization : | |
| | | Psychiatric Hospitalization Module – Time Since Most Recent Discharge | |

## Additional Eligibility Criteria

Criteria C

* Outpatient therapy or partial hospitalization has been attempted and failed OR a psychiatrist has documented reasons why an inpatient level of care is required ◯ Yes ◯ No

Criteria D

* Check the Medicaid psychiatric inpatient hospitalization criteria below that the client meets

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8

Criteria E

* Check the Medicaid psychiatric inpatient hospitalization criteria below that the client meets ◯ Yes ◯ No

Notes on Clinical Eligibility

System Clinical Eligibility Determincation: ☐ Criteria A (Met) ☐ Criteria B (Met) ☐ Criteria C (Met) ☐ Criteria D (Met) ☐ Criteria D (Met)

## Signatures

* By signing below, the Treatment Team indicates agreement that the chosen Waiver Services for this individual are not available through other resources and are necessary to prevent institutionalization and assure his/her health and safety.

* Licensed Practitioner of the Healing Arts (LPHA) *Date

Client Signed Refused Unable to Sign

Client *Date

Physician *Date

Physician signature is only required when individual is being denied Waiver Services based on Medicaid Inpatient Psychiatric Admission Guidelines

*Legally Authorized Representative(LAR) *Date

Signed

No LAR, legally emancipated

## HHSC Review and Approval

Approve Approve Based on Appeal Deny *Date

Reviewer Notes

HHSC Authorized Reviewer

*Document Status

Document Status Date

## Signatures

Client Signature _____ Date _____

LPHA Signature _____ Date _____

LAR Signature _____ Date _____

Physician Signature _____ Date _____