DELAWARE HEALTH AND SOCIAL SERVICES
Division of Substance Abuse and Mental Health

COMMUNITY SUPPORT PROGRAM

Recertification Form

Part I

Completed by CSP Program

Consumer Name: _____
Last First M.I.

Consumer MCI# _____ (10 digits) D.O.B. ____/____/____ mm dd year

Mediciad ☐ Yes ☐ No

Part II

Physician Recertification (Completed by CSP Physician)
(Due 15 days before current certification period terminates)

CSP Program Name: _____
Admission Date: ____/____/____
Date Current Certification Terminates ____/____/____
Certification Due Date ____/____/____ (15 days before termination)

Based on the indications of the Delaware Assessment Packet completed on ____/____/____ and my examination of ____/____/____ documented in the client record, I hereby certify that the provision of the following community support rehabilitation services _____ (**are**), _____ (**are not**) medically necessary for the above named consumer.

☐ CTT Level I ☐ CTT Level II
☐ Other ☐ Licensed MH Group Home

Recertification Effective Date: ____/____/____ End Date: ____/____/____

Physician Signature: _____ Date: ____/____/____

Part III

CMHC/DPC Review of Certification (completed by CMHC)
(Due 15 days after recertification)

The physician's certification and the Delaware Reassessment Packet have been reviewed by the Community Mental Health Center and found to be complete.

Agency Authorized Representative Signature: _____ Date: ____/____/____

Authorized Units: ☐☐☐☐ Authorized Months/Days: ☐☐☐