Delaware Health and Social Services
DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

LONG TERM CARE PROGRAM (LTC)
RECERTIFICATION FORM

PART I (Completed by the LTC Provider)

Primary Service Provider and Program: _____

Consumer Name _____
Last First M.I.

Consumer MCI # ___ ___ ___ ___ ___ ___ DOB ___ ___ ___ ___ ___ ___ ___ ___
M M D D Y Y Y Y

Medicaid ___YES ___NO

X _____ (Agency Authorized Representative)

PART II Physician Recertification (Due 15 days before current certification period ends)

Admission Date _____/_____/_____

Date Current Certification Terminates _____/_____/_____

Certification Due Date _____/_____/_____ (15 days before Termination)

Based on the indications of the **DSAMH Annual Long Term Care Re-Determination Application** reviewed on ____/____/_____ (date) and my examination of ____/____/____ (date) documented in the client record, I hereby certify that the following community support rehabilitation services (_____ are) (____ are not) medically necessary for the above named consumer.

(Note: submit clinical justification and psychiatric evaluation if services are not medically necessary.)

___ CRISP ___ ACT ___ ICM ___ Licensed MH Group Home

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

X _____ (Physician) ____/____/____ (Date)

PART III EEU Review of Certification (Completed by EEU; due 5 days after recertification)

The physician's certification have been reviewed by the Eligibility and Enrollment Unit and found to be complete.

X _____ (EEU Staff) Date ____/____/____