DIADEM HEARTS
restoring the pride of the human mind

HCBS-AMH Referral/ Criteria Form

Last Name: _____ First Name: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Medicaid # _____ DOB: ____/_____/_____ Medicare # _____

Emergency Contact # / Relationship: _____ Phone#: ( )_____-_____

Case Worker Name: _____ Phone#: ( ) _____-_____

Monthly Income: $_____ Living Arrangement: _____

Diagnosis(s): _____

Eligibility Requirements

- Has the client had long Term Psychiatric Hospitalization- a total of 1095 days (3 years cumulative or consecutive) in an in-patient psychiatric hospital during the 5 years before the referral? _____
- Jail Diversion-4 arrests and 2 psychiatric crises during the 3 years before the referral? _____
- Emergency Room Diversion-15 emergency room visits (for any reason) and 2 psychiatric crises during the 3 years before the referral? _____
- Does the client have a primary diagnosis of SMI? _____
- Is the client 18 years of age? _____
- Does the client have an income below 150% Federal Poverty Level? (Less Than $1,956.25 monthly or $23,475 annual) _____
- Will the client be able to live in the community with HCBS-AMH services (meet clinical and functional criteria)? _____

Collection of information taken by: _____

Date: _____