

POLICY OF STATE OF DELAWARE DEPARTMENT OF CORRECTION	POLICY NUMBER E-13	PAGE NUMBER 1 of 60
	RELATED NCCHC/ACA STANDARDS: P-E-13(Essential), MH-E-10(Essential), J-E-13(Essential), 4-4347(Essential)	
CHAPTER: 11 BUREAU OF CORRECTIONAL HEALTHCARE SERVICES	SUBJECT: DISCHARGE PLANNING	
EFFECTIVE DATE: 11/14/2007 REVISED: 4/13/09; 4/23/2010; 1/24/2011; 1/6/2014; 10/05/2016		
APPROVED FOR PUBLIC RELEASE		

- I. **AUTHORITY:** Bureau of Correctional Healthcare Services (BCHS)
- II. **PURPOSE:** To provide discharge planning services for offenders with serious medical conditions and /or behavioral health needs to successfully reintegrate into the community and provide reentry planning support for offenders with a high risk/high need.
- III. **APPLICABILITY:** All Delaware Department of Correction (DDOC) employees, provider staff, offenders, and any outside healthcare provider servicing DDOC offenders.
- IV. **DEFINITIONS:** See glossary
- V. **SUMMARY OF CHANGES:**
This policy has significantly changed and shall be reviewed in its entirety. This policy and corresponding attachments have been revised to support the adoption of a case management system for discharge planning and reentry services.
- VI. **POLICY:** The Delaware Department of Correction shall provide and support discharge planning, the coordination of care, and reentry efforts to offer a continuum of care for medical and behavioral health services for offenders to make a successful reintegration into the community.

A. Framework

The discharge planning and reentry process shall include three (3) primary elements:

1. **Needs Assessment:** The needs assessment process begins upon entry into the facility with an inquiry of the offender's medical and behavioral health providers, current support system and identification of basic needs required for reentry. The process is ongoing as identified needs may change over time.
2. **Discharge and Reentry Planning:** Discharge and reentry planning services shall include a process to support reintegration into the community.
 - a. Offenders identified as having a serious medical condition, for example those enrolled in a chronic care clinic, and/or who are on the current behavioral health roster shall receive BCHS Discharge and Reentry Planning Services.

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These services include discharge coordination activities and completion of a written discharge plan for all offenders incarcerated for a minimum of thirty (30) days.

- b. Discharge and Reentry planning will be provided upon request or recommendation for offenders who have high risk/high need challenges.
 - i. High risk /high need challenges related to reentry include: lack of housing, little or no support system, sex offender status, restrictive housing placement, lack of health care, and/or a significant felony history.
 - c. Discharge and re-entry requires active planning and coordination of resources that may assist the offender identify and access community services such as: housing, employment, food assistance programs, entitlement and/or health care programs.
 - d. Discharge and reentry shall involve the participation of the offender.
3. Transitional Support: Successful Re-entry requires active planning and coordination of resources between the discharge planner, the DOC counselor, treatment providers, reentry program coordinators, and the offender. It is also built upon collaborative relationships with DOC providers and other State agencies, such as the Department of Health and Social Services, to help eligible offenders obtain Medicaid, Medicare, VA or other health benefits upon release.

B. Needs Assessment

1. The Discharge and Reentry Planning Service team shall facilitate an orientation session for those individuals detained for a minimum of 30 days and a session for sentenced offenders who may not be receiving on-going health care services for information and referral purposes.
 - a. Offenders shall complete a Reentry Needs Questionnaire (Attachment A) and the Discharge Planner will review the completed form and collaborate with the DOC counselor for any applicable referrals.
2. The Discharge Planner shall also facilitate a Discharge Planning Orientation eight (8) months prior to release for the following populations:
 - a. Sentenced offenders diagnosed with a serious medical condition,
 - b. Offenders placed on the behavioral health roster; and,
 - c. Offenders identified as having high risk/high need challenges.

During the orientation the offender shall receive information/materials to evaluate his/her reentry status to develop a discharge plan. Discharge planning services will begin immediately upon completion of the orientation.

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3. Discharge planning and reentry services will also be provided for offenders who are placed in restrictive housing 60 days prior to their anticipated release.

C. Discharge Planning and Reentry Services

1. Discharge planning and reentry support services involve a combination of tasks including:
 - a. A review of the offender's reentry needs
 - b. Completion of a written discharge plan
 - c. Recommendations and implementing action steps such as coordinating the availability or distribution of medication
 - d. The completion of all appropriate documents including the Release of Information Form.
 - i. The Discharge Planner shall obtain written consent by securing the offender's signature on a DDOC Release of Information (ROI) form (Attachment B). The Discharge Planner shall file a copy of the signed Release of Information (ROI) form in iCHRT. The Discharge Planner or assigned staff person shall coordinate the referral process to initiate recommended services.
 - e. Follow-up services, providing guidance and scheduling appointments for medical or community based services, or providing notification to regulatory agencies (i.e. public health, sex offense registry) regarding the offender's release to the community.
2. The unexpected release of an offender diagnosed with a serious medical or high risk/high need, shall be supported to the extent possible to support a continuum of care.
3. The provider Discharge Planner will maintain a log identifying offenders requiring discharge and reentry planning services beginning no later than (8) months prior to the preliminary release date. Preliminary discharge information shall be used to create a discharge planning log.
 - a. The Discharge Planning log will serve as tracking mechanism to include information on discharge dates, referrals, re-entry support services, etc. to monitor the continuum of care.
4. The Discharge Planner, medical, behavioral health and pharmacy provider staff shall have an initial meeting at least 6 months prior to the offender's release to identify potential challenges in obtaining post release services. Discussion will include a review of the offender's Reentry Needs Questionnaire responses, the offender's diagnostic and treatment history before and during incarceration, and information to assist with making appropriate referrals and linkages to the community.

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5. The Discharge Planner in collaboration with the DDOC counselor and the identified offender will meet to establish goals and prepare an action plan to achieve a healthy lifestyle.
6. The Discharge Planner shall complete a Discharge Plan (Attachment C) no later than 4 months prior to release with the offender to be revised or updated as needed to reflect the availability and confirmation of arrangements to meet the offenders' needs. The discharge plan is finalized, to the extent possible, 60 days prior to the anticipated discharge date. The Discharge planner will notify medical and behavioral health providers of status updates and preliminary discharge date changes to assure completion of the offender's discharge plan including confirmation of identified reentry needs for:
 - a. Ongoing medical needs (including medical equipment)
 - b. Ongoing behavioral health treatment areas, and/or
 - c. Post release aftercare services & follow up
7. The Discharge Planner shall notify the offender of significant developments that impact the discharge plan and shall be given an opportunity to approve or disapprove any changes. The Discharge Planner shall enter a progress note documenting the changes, the recommendations and the offender's response into iCHRT. An addendum shall be written and signed to document changes to the plan (up to the point of discharge).
8. Upon completion of the discharge plan, the discharge planner will make a reasonable attempt to schedule follow up appointments with identified community providers. Scheduling, including the exchange of clinically relevant information, shall be completed 30 days prior to discharge. The Discharge Planner shall update referral status and record appointment information in the Discharge Plan.
9. One (1) month prior to discharge, the Discharge Planner shall record all scheduled appointments onto the Discharge Reentry Summary (Attachment D). The Discharge Reentry Summary (Attachment D), the Post Release Health Care Information Sheet (Attachment E) and Medical Reentry Resource Guide (Attachment F), along with other applicable information is prepared and given to the offender at the time of release. Distribution of information may include:
 - a. Patient action plan/self-care instructions
 - b. List of medications and reason for use
 - c. Scheduled appointments and provider information
 - d. List of community medical and behavioral health resources
 - e. Instructions addressing the reentry needs and concerns of the offender.
10. The medical provider or designee shall make arrangements for the offender to receive his or her prescribed medication at the time of release.

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- a. The offender shall receive a (maximum) 30 day supply of prescription medication prior to discharge. Detained individuals who are not sentenced shall be given the remainder of their prescription medication supply if time does not allow for ordering a full 30-day supply.
 - b. The Discharge Planner shall make arrangements to give a 30-day supply of diabetic testing supplies for those Chronic Care identified offenders receiving medical treatment and medications related to Diabetes.
 - c. Offenders provided medications upon release are required to sign a statement confirming the receipt of medication(s) including the applicable medication information sheet. The signed form shall be placed in the offender's electronic health record.
11. The offender shall receive notification of the DDOC Policy 11-H-04 - Availability and Use of Health Record - and instructions on how to request a copy of their health record.
 12. The Discharge Planner shall write a progress note reflecting the final discharge plan in iCHRT to include:
 - a. A brief description of the offender at the point of release and notation of any concerns related to the offender's reentry into the community.
 - b. Any information pertaining to an unplanned discharge, including applicable post release activity with a brief description of the offender at the point of release.

D. Transitional Support

1. In accordance with the BCHS Policy E-12, Continuity of Care Policy, the Discharge Planner shall assure that all protocols are followed for offenders transferring to another DDOC facility with a serious medical condition and/or behavioral health condition. The transfer process shall include a behavioral health treatment debriefing to the receiving facilities treatment team/clinicians. The debriefing shall include a progress status report of the medical, behavioral health and substance use treatment plan, and provide recommendations for continued treatment.
2. The discharge planner will follow-up with the identified community, medical and/or behavioral health provider at 30 and 60 days post discharge. The discharge planner shall maintain a log documenting the status of appointments as scheduled.

VII. SPECIAL CONSIDERATIONS:

A. Offenders Needing Crisis Intervention Services (CIS)

1. The Discharge Planner shall contact the DHSS Crisis Intervention Service (CIS) Hotline to arrange assistance for individuals to be released from DDOC custody who are in crisis but are not in imminent danger or does not present an imminent danger to self or others. The following criteria must be met:

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- a. The individual is not currently in need of hospitalization
 - b. The individual does not have any community resources
 - c. The individual suffers from a mental health or substance use disorder
2. The individual does not have any housing arrangements and is not able to safely travel to a shelter as a result of his/her mental health disorder and/or substance use disorder.

B. Offenders Placed on Psychiatric Close Observation (PCO)

1. Individuals placed on PCO (see Policy 11-G-05), or need immediate psychiatric care, or present a danger to self or others, who are within 24 hours of release from DOC custody, shall be assessed by a licensed psychiatrist or DSAMH Certified Mental Health Screener in accordance with Title 16, Chapter 51 of the Delaware Code. The licensed psychiatrist or the DSAMH Certified Mental Health Screener in consultation with the psychiatrist shall decide the continuum of care for treatment within 24 hours of the offender's release.
 - a. Offenders on PCO who are being discharged from the infirmary must be seen by a psychiatrist or psychiatric nurse practitioner and require a physician's order to be discharged.
2. If the offender requires inpatient treatment, the psychiatrist or the DSAMH Certified Mental Health Screener shall make a referral via the DSAMH-Enrollment and Eligibility Unit (DSAMH-EEU).
 - a. The DSAMH Certified Mental Health Screener shall complete the 24- Hour Emergency Detention Form (Attachment G) and the Initial Behavioral Health Assessment Form (Attachment H) and fax them to the DSAMH-EEU.
 - b. The Mental Health Screener will call the DSAMH-EEU and provide a brief summary of the situation immediately before or after faxing the required documents. Additional treatment history information may be requested from the provider to support the referral process.
 - c. If a Mental Health Screener is not available, a psychiatrist must complete a Certificate for Provisional Hospitalization - Civil Commitment (Attachment I) and an Initial Behavioral Health Assessment Form (Attachment H) and fax the completed forms to the DSAMH-EEU.
 - d. The EEU will notify the Mental Health Screener or psychiatrist of inpatient bed availability, the facility contact and transport drop off location (emergency room, triage/intake unit).
 - e. The DDOC will transport the offender to the facility indicated by the EEU. In the event the offender is being sent to the local ER, DDOC security staff will contact hospital security and inform them that the offender is being released

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from DDOC custody and is being transported to the hospital for assessment and/or admission.

3. If the offender does not require inpatient treatment or does not present an imminent danger to self or others, the Psychiatrist or the DSAMH Certified Mental Health Screener shall follow the offender's written discharge plan and/or contact CIS for assistance.

C. Significant Mental Illness

1. The Discharge Planner will collaborate with the Mental Health Clinician and the offender to assure the implementation of the discharge plan throughout the reentry planning process.
 - a. The Mental Health Clinician will complete a DSAMH Clinical Enrollment Form (Attachment J) to be submitted to DSAMH Eligibility and Enrollment Unit for any Offender meeting clinical eligibility for DSAMH Long Term Care (LTC) system Services.
 - b. The behavioral health clinician shall document a final progress note into iCHRT that summarizes the provision of mental health services. Documentation shall include:
 - i. Description of services provided
 - ii. The offender's progress or lack of progress in treatment
 - iii. The offender's status/condition upon the conclusion of treatment
 - iv. Treatment recommendations

D. Communicable Disease and Infection Control

1. The Discharge Planner shall notify the DE Division of Public Health of the release date and other pertinent information for any offender currently receiving treatment for a chronic infectious disease. The Discharge Planner shall complete an HIV Psychosocial Discharge Assessment form (Attachment K) for all offenders who are HIV positive, at least 60 days prior to release. Communication to the appropriate authority shall be consistent with patient confidentiality to the greatest extent permitted under the circumstances.

VIII. POLICY IMPLEMENTATION:

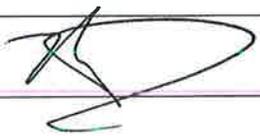
- A. The Contract Provider's Medical and Behavioral Health Divisions shall collaborate to develop a site-specific procedure within 30 days of the effective date of this policy for each Level V and Level IV facility implementing this policy and coordinating the procedure with BCHS.
 1. All provisions of this policy shall be made available to BCHS for review upon request.

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Attachment Index

- Attachment A: Reentry Needs Questionnaire
- Attachment B: Release of Information Form
- Attachment C: BCHS Discharge Plan
- Attachment D: Discharge Re-entry Summary
- Attachment E: Post Release Health Care Information Sheet
- Attachment F: Medical Re-entry Resource Guide & Release Plan
- Attachment G: 24-Hour Emergency Detention Form
- Attachment H: Behavioral Health Assessment Form
- Attachment I: Psychiatrist's Certificate for Provisional Hospitalization
- Attachment J: DSAMH Eligibility and Enrollment Application Form
- Attachment K: HIV Psychosocial Discharge Assessment Form

Approval:

Date of Policy Revision	Marc Richman, PhD. BCHS Bureau Chief,	Date	Robert Coupe Commissioner	Date
10/05/2016		10/25/16		10/25/16

References:

- National Commission on Correctional Health Care: Standards for Health Services in Prisons, 2014, P-E-13
- National Commission on Correctional Health Care: Standards for Health Services in Jails, 2014, J-E-13
- National Commission on Correctional Health Care: Standard for Mental Health Services in Correctional Facilities, 2015, MH-E-10
- American Correction Association: Standards for Adult Correctional Institutions. 4th Edition, 2014 Supplement. 4-4347

Reentry Needs Questionnaire

The following document is used for discharge planning to determine each individual's post release needs. This document shall be completed following identification of a potential concern and information updated as necessary.

Offender's Name:	DOB:	SBI#
Facility:	Next Level Placement:	Projected Discharge Date:
Primary Care and General Medical Care		COMMENTS
Do you have a primary care physician that you have seen in the last year? If yes, please provide name and location of practice.	YES	NO
Are you presently managing or receiving treatment for a medical or health condition? (Examples are: diabetes, pregnancy, physiological withdrawal from drugs/alcohol requiring detoxification, recent pneumonia, hypertension, liver or cardiovascular disease, tuberculosis, hepatitis, etc.)	YES	NO
Behavioral Health Care		COMMENTS
Have you been seen for a mental health or substance use issue within the last 12 months? If yes, please provide name and location of practice.	YES	NO
Do you think you will need mental health treatment following your release?	YES	NO
Do you think you will need treatment for substance use issues following your release?	YES	NO
Housing		COMMENTS
What county/city did you live in prior to your incarceration?		
Do you intend to return to the same county/city following your release?	YES	NO
Do you think returning to the same county/city will help your ability to stay out of DOC facilities?	YES	NO
Do you think returning to the same county/city will hinder your ability to stay out of DOC facilities?	YES	NO
Do you have any restrictions on where you will be able to live once you are released?	YES	NO
Will you need assistance in finding housing/or a place to live upon discharge?	YES	NO
Family & Community Support System		COMMENTS
How would you describe the relationship status with your family?		
Will you continue to have the support of your family and/or community upon your re-entry to the community?	YES	NO
Do you think you will need assistance or some kind of counseling to mend relationships with family members?	YES	NO
Are you currently involved in or need resolution to a domestic issue involving members of your family?	YES	NO
Do you have children?	YES	NO

Are you involved with their support?	YES	NO	
Do you have any restrictions involving contact with your family?	YES	NO	
Do you have any restrictions involving contact with non-related individuals?	YES	NO	
Have you been court ordered to pay child support or alimony?	YES	NO	
Do you have a resource for transportation once you are released from DOC Custody?	YES	NO	
Income			COMMENTS
Did you have a legal source of income prior to your incarceration?	YES	NO	
Were you receiving benefits (GA, food stamps, unemployment insurance, etc.)?	YES	NO	
Were you receiving Social Security (SS, SSD, SSI) benefits prior to your incarceration?	YES	NO	
If yes, will you need assistance in re-establishing benefits following your release?	YES	NO	
Do you think you could benefit from budgeting and money management training?	YES	NO	
Employment and Education Plan			COMMENTS
Were you employed prior to your incarceration?	YES	NO	
Will you be able to return to this job upon release?	YES	NO	
Were you in school or some form of education or job skills training program prior to your incarceration?	YES	NO	
Do you have plans to complete your education and/or training program upon your release?	YES	NO	
Other Post Release Needs			COMMENTS
Aging & Disability Services	YES	NO	
Alien Registration Card	YES	NO	
Birth Certificate	YES	NO	
Certificate of Naturalization	YES	NO	
Driver's License/State Issued ID	YES	NO	
Health Insurance	YES	NO	
Medication/Prescription Savings Card	YES	NO	
Military Discharge Papers	YES	NO	
Social Security Card	YES	NO	
Veteran Benefits	YES	NO	
Veteran/Military ID	YES	NO	
Other:			

The information in this form shall be reviewed with you prior to your projected release date. You will have an opportunity to discuss your post release needs and/or develop an action plan as part of your formal discharge and reentry plan into the community.

Offender's Signature: _____ **Date:** _____

Discharge Planner's Signature: _____ **Date:** _____

Review Date: _____



DELAWARE DEPARTMENT OF CORRECTION RELEASE OF INFORMATION AUTHORIZATION

Name: _____ **SBI:** _____ **Date of Birth:** _____

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

I am either the patient named above or the patient's legally authorized representative. If signing in a representative capacity, I have attached hereto legal proof of my representative status (e.g., power of attorney, letters testamentary, letters of administration, etc.). By signing this form, I authorize and release the Contract Provider – Connections CSP, the Delaware Department of Correction and their respective employees, officers and agents from liability relating to the release of the following information, including protected health information included in my medical records.

Records released from: Name/Agency: _____ Address: _____ Phone Number: _____	Records released to: Name/Agency: _____ Address: _____ Phone Number: _____
--	--

Information to be released from the Dates: _____ To: _____

- Records or Information to be released:**
- I authorize the release of all records identified below
 - I authorize the release of only those records specifically checked below

<input type="checkbox"/> Admission Records	<input type="checkbox"/> Medical History/Records	<input type="checkbox"/> Mental Health Evaluations
<input type="checkbox"/> Diagnostic Reports	<input type="checkbox"/> Medical Screenings & Assessments	<input type="checkbox"/> Psychiatric Evaluations
<input type="checkbox"/> Discharge Reports	<input type="checkbox"/> Medications (please attach list)	<input type="checkbox"/> Substance Use History & Evaluations
<input type="checkbox"/> HIV Status and Treatment	<input type="checkbox"/> STD Status and Treatment	<input type="checkbox"/> Treatment Plan
<input type="checkbox"/> Immunization History	<input type="checkbox"/> Behavioral Health Screenings & Assessments	<input type="checkbox"/> Other (specify): _____

Disclosure is being made for the purpose(s) listed below:

<input type="checkbox"/> Legal	<input type="checkbox"/> Judicial/Courts	<input type="checkbox"/> Medical
<input type="checkbox"/> Insurance	<input type="checkbox"/> Other (Specify): _____	

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, and/or drug and/or alcohol use. If I have authorized the release of records by checking one or more of the boxes above, you are hereby specifically authorized to release all healthcare information relating to such testing, diagnosis, and/or treatment of the after mentioned conditions. I understand that my records are protected under Federal privacy regulations with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and Federal Regulation governing Confidentiality of Alcohol and Drug Abuse patient Records 42 CFR, Part 2, if applicable. I understand that my health information specified above will be disclosed pursuant to this authorization, and that the recipient of the information may disclose it to others, and that any information disclosed by the BCHS Healthcare Provider may no longer be protected by HIPAA. However, federal confidentiality regulations, 42 CFR, Part 2, will continue to protect the confidentiality of information that identifies me as a patient in an alcohol or the substance abuse treatment program. I understand medical records cannot be disclosed without the written consent, except as provided for under federal or state law.

This authorization expires and becomes invalid on the following date: _____, or one year from the date of execution if no date is specified, and is subject to revocation by me at any time if provided in writing to the Department of Correction, Bureau of Healthcare Services, except to the extent that disclosure has been made in reliance on this authorization prior to receipt of such revocation. To be valid, notice of revocation must be signed by me and delivered to _____. I understand I am not required to sign this authorization to receive healthcare treatment. I understand that, once information is disclosed pursuant to this Authorization, it is possible that it will no longer be protected by applicable privacy laws and could be re-disclosed by the person or agency that receives it. I do not authorize such secondary disclosure with respect to any records protected by 42 CFR, Part 2. State law provides that a healthcare provider may charge a reasonable fee for these records. Upon the request of the Department of Correction, any personal representative must show documentation of the legal basis for the relationship to the patient prior to any record production.

Signature of patient or authorized representative: _____ Date: _____

AUTHORIZED REPRESENTATIVE'S NAME AND RELATIONSHIP TO PATIENT WHO HAS THE AUTHORITY TO ACT FOR PATIENT:

Printed Name: _____ Relationship: _____

My Signature verifies my refusal in the release of any and all information to the above named individual:

Signature of patient or authorized representative: _____ Date: _____

Delaware Department of Correction
BCHS Discharge Plan

Offender Name _____ Gender _____ SBI# _____
 SSN# _____ DOB _____ Anticipated Release Date _____
 Facility _____ Next Placement Level _____

A. Risk Level, Treatment, and Criminogenic

Was the offender's assessment instruments reviewed? Yes _____ No _____ LSI-R score _____
 High _____ High/Moderate _____ Moderate _____ Low/ Moderate _____ Low _____
 ASI score/level _____ RNR _____

B. Prison Program Completion

Substance Use Programming	Yes	No	Program:
Self-Help Group	Yes	No	Program:
Domestic Violence	Yes	No	Program:
Education Program	Yes	No	Level:
GED Program	Yes	No	Level:
Job Skills Training	Yes	No	Certifications:
Work Program	Yes	No	Position:
Parent Education Program	Yes	No	Name:
Sexual Offender Treatment	Yes	No	Completion Date: Tier Level:
Other	Yes	No	
Other	Yes	No	
Other	Yes	No	

C. Identification Documents Need

Social Security Card	Yes	No	Veteran Identification Card	Yes	No
Birth Certificate	Yes	No	Passport	Yes	No
Alien Registration Card	Yes	No	State ID/Driver's License	Yes	No
Picture Identification	Yes	No	Certificate of Naturalization	Yes	No
HS Diploma/GED	Yes	No	Military Discharge Papers	Yes	No

D. Benefit Eligibility Need

Public Assistance	Yes	No	DDDS Waiver	Yes	No
Medicaid	Yes	No	Long Term Care Medicaid	Yes	No
Food Stamps	Yes	No	Medicare	Yes	No
SSD/SSI	Yes	No	Health Care	Yes	No
Veteran Benefits	Yes	No	Other	Yes	No

I-ADAPT Enrollment	Yes	No	Enrollment Date:

Name _____ SBI # _____ Plan Date _____

E. Health Care Need

Medical Treatment Need	Yes	No	Comments
Follow Up Recommendations	Yes	No	
Medical Equipment Need	Yes	No	
Medical Inpatient/Rehabilitation	Yes	No	
Long Term Residential Care/Hospice	Yes	No	
Medical Treatment Area		Last Treatment Date	
Behavioral Health Treatment Need	Yes	No	Comments
Current Self-Harm/Safety Concerns	Yes	No	
History Self-Harm/Safety Concerns	Yes	No	
EEU Psychiatric Commitment	Yes	No	
EEU Clinical Determination	Yes	No	
Psychotropic Medication	Yes	No	
Mental Health Recommended Level of Care [] No MH Treatment Need	<input type="checkbox"/> Outpatient <input type="checkbox"/> Psychiatric Inpatient <input type="checkbox"/> Residential/MH Group Home <input type="checkbox"/> Intensive/ACT Services <input type="checkbox"/> Medication Monitoring		
Substance Use Treatment Level of Care [] No SU Treatment Need	<input type="checkbox"/> Intensive Outpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Residential/Sober House <input type="checkbox"/> Self-Help <input type="checkbox"/> Medication-Assisted Treatment		
Current Diagnosis (Include Substance Disorder in Axis I)			

F. Housing Need:

Is the offender subject to Restricted Housing?	Yes	No
Has concern about being homeless upon discharge?	Yes	No
Has confirmed plan for Housing?	Yes	No
Will be living in single home upon discharge?	Yes	No
Address:		
Phone:		
County of Residence:		
Number of Children in Household:		Number of Others in Household:
Will be living in a group setting upon discharge	Yes	No
Has expectation to be released to a Shelter?	Yes	No
Has expectation to be released to a Sober House?	Yes	No
Has expectation to be released to a Nursing Home?	Yes	No
Has expectation to be released to a Treatment Facility?	Yes	No
Other: (Describe)		

Name _____ SBI # _____ Plan Date _____

Action Steps and Referrals

Issue:		Medical Care
Challenges/Potential Problems in addressing this issue		
Discharge/Reentry Goal to address this issue		
Action Steps (Offender)		
Action Steps (Discharge Team)		
Action Steps (Other)		
Comments		
Agency Name/Contact Person		Referral Contact Date:
Comments		
Disposition/Appointment Time		

Action Steps and Referrals

Issue:		Behavioral Health Care
Challenges/Potential Problems in addressing this issue		
Discharge/Reentry Goal to address this issue		
Action Steps (Offender)		
Action Steps (Discharge Team)		
Action Steps (Other)		
Comments		
Agency Name/Contact Person		Referral Contact Date:
Comments		
Disposition/Appointment Time		

Name _____ SBI # _____ Plan Date _____

Action Steps and Referrals

Issue:		Housing
Challenges/Potential Problems in addressing this issue		
Discharge/Reentry Goal to address this issue		
Action Steps (Offender)		
Action Steps (Discharge Team)		
Action Steps (Other)		
Comments		
Agency Name/Contact Person		Referral Contact Date:
Comments		
Disposition/Appointment Time		

Action Steps and Referrals

Issue:		Family & Community Support
Challenges/Potential Problems in addressing this issue		
Discharge/Reentry Goal to address this issue		
Action Steps (Offender)		
Action Steps (Discharge Team)		
Action Steps (Other)		
Comments		
Agency Name/Contact Person		Referral Contact Date:
Comments		
Disposition/Appointment Time		

Name _____ SBI # _____ Plan Date _____

Action Steps and Referrals

Issue:		Financial Plan & Income	
Challenges/Potential Problems in addressing this issue			
Discharge/Reentry Goal to address this issue			
Action Steps (Offender)			
Action Steps (Discharge Team)			
Action Steps (Other)			
Comments			
Agency Name/Contact Person		Referral Contact Date:	
Comments			
Disposition/Appointment Time			

Action Steps and Referrals

		Employment and Education Plan	
Challenges/Potential Problems in addressing this issue			
Discharge/Reentry Goal to address this issue			
Action Steps (Offender)			
Action Steps (Discharge Team)			
Action Steps (Other)			
Comments			
Agency Name/Contact Person		Referral Date:	
Comments			
Disposition/Appointment Time			

Name _____ SBI # _____ Plan Date _____

Action Steps and Referrals

Intervention Issue:		
Challenges/Potential Problems in addressing this issue		
Discharge/Reentry Goal to address this issue		
Action Steps (Offender)		
Action Steps (Discharge Team)		
Action Steps (Other)		
Comments		
Agency Name/Contact Person		Referral Contact Date:
Comments		
Disposition/Appointment Time		

Action Steps and Referrals

Intervention Issue:		
Challenges/Potential Problems in addressing this issue		
Discharge/Reentry Goal to address this issue		
Action Steps (Offender)		
Action Steps (Discharge Team)		
Action Steps (Other)		
Comments		
Agency Name/Contact Person		Referral Contact Date:
Comments		
Disposition/Appointment Time		

Name _____ SBI # _____ Plan Date _____

Intervention Approval

Plan Approval	Referral Date/Status	Appointment Information/Contact
Benefit Enrollment Application (Disability)		
Benefit Enrollment Application (General Assistance)		
Benefit Enrollment Application (Health Insurance)		
Benefit Enrollment Application (Veteran)		
Benefit Enrollment Application ()		
Benefit Enrollment Application ()		
ADRC (Aging & Disability Resource Center) Referral		
Employment & Education Referral		
Family & Community Support System Referral		
Financial Planning Referral		
Housing Application/Referral		
Self Help Group Support Referral		
Other:		
Medical Provider/Appointment		
Medical Provider/Appointment		
Mental Health Provider/Appointment		
Substance Use Treatment Provider Appointment		
Other:		
Other:		

Full plan completed and discussed with offender Yes No

Offender's Signature Date

Counselor's Signature Date

Supervisor's Signature Date

Discharge Reentry Summary

(Distribute Upon Release)

Name:		Re-entry Date:
		SBI#
Transportation Arrangement: []Family/Friend []Bus/Taxi [] No Plan/Walking []After Care Program		
Re-entry Housing Arrangement: []Own Home []Family/Friend []Hotel []Shelter []After Care TX Program		
Discharge/Re-entry Address:		County:
Street _____		
City _____ Zip Code _____		

Community Reentry Plan and Recommendations for Services

Identified & Recommended Services:	Action Plan	Appointment/Provider Information
Aging & Disability Services		
Education Program:		
Employment		
Family Reunification		
Health Care Benefits		
Housing		
Identification Documents		
Job Skills Training Program		
Legal Services		
Life Skills & Money Management		
Medical Care		
Mental Health Treatment		
Parenting Classes		
Probation and Parole Contact		
Public Assistance		
Re-entry Support Services(Community/Ministry)		
Re-entry Support (IADAPT)		
Social Security Benefits		
Substance Use Treatment		
Veterans Benefits		
Other:		

Health Wellness Plan/Medical/Medication Summary

Medical Care--You need to make an appointment and review the following medical conditions with your community based medical provider.	Patient Care Instructions	Appointment/Provider Information
Medications--You have been given a list of your current medications and/or been issued a supply of medication to treat your conditions. Your community based medical provider will be able to assist you with your medications during your appointment.	Please take your medication as instructed. Keep your scheduled appointment and/or see your health care provider within the next 28 days.	

Substance Use Treatment Plan

You would benefit from a follow up with a substance treatment provider.	Patient Care Instructions	Appointment/Provider Information

Mental Health Treatment

Identified & Recommended Services:	Keep your appointment or arrange to see a community based mental health provider within the next 28 days.	Appointment/Provider Information

Send all request to obtain your health record to:	BCHS Department of Records 245 McKee Road Dover, DE 19904 302-739-5601
---	---



STATE OF DELAWARE
DEPARTMENT OF CORRECTION

POST RELEASE HEALTH CARE INFORMATION SHEET

Offender _____

SBI _____

30 Day Medication Supply

Upon discharge you will receive a 30 day supply of essential prescribed, non-narcotic medications.

- Ensure you speak with a nurse as you are processed of a DOC facility.
- If the nurse does not have your 30 day supply, ask how you can receive it after your release.
- If there is still a concern in getting your medications, call the DOC Bureau of Correctional Healthcare Services.
- If you are not able to pay for a medication refill, contact the Partnership for Prescription Assistance Program (page 2).

Your Medical Record

You may request that your medical record be sent to your healthcare provider. You must complete and sign a Release of Information form (ROI) that specifies the information you want released and the name and address of where the information is to be sent.

- Ask to sign a Release of Information form during your meeting with the discharge nurse.

Medical, Dental and Behavioral Health Resources Dental health services are available at locations marked with asterisk (*)

It is important that you continue to receive medical, dental and/or behavioral health care following your release. You will need an appointment within 30 days of your release to prevent an interruption in your care and/or from running out of your prescribed medications. The Discharge Planner can assist you in selecting a new healthcare provider and will schedule an appointment upon your request.

- Discuss your need for a referral to a doctor or clinic in the community.
- NEW CASTLE
 - Westside Family Healthcare/Westside - 1802 W. 4th Street, Wilmington, DE 19805 / 302-655-5822 *
 - Westside Family Healthcare/Northeast- 908B E. 16th Street, Wilmington, DE 19802 / 302-575-1414
 - Westside Family Healthcare/Newark- 27 Marrows Rd, Newark, DE 19713 / 302-455-0900
 - Westside Family Healthcare/Bear- 404 Foxhound Drive, Bear, DE 19701 / 302-836-2864
 - Westside Family Healthcare/Middletown – 306 E. Main Street, Middletown, DE 19709 / 302-378-4489
 - Henrietta Johnson Medical Center/Claymont – 3301 Green Street, Claymont, DE 19703 / 302-798-9755
 - Henrietta Johnson Medical Center/Eastside – 600 N. Lombard Street, Wilmington, DE 19801 / 302-761-4610*
 - Henrietta Johnson Medical Center/South Bridge - 601 New Castle Ave, Wilmington, DE 19801 / 302-655-6187*
 - Wilmington Mental Health Center- 1906 Maryland Ave, Wilmington, DE 19805/ 302-778-6900
 - Crisis and Psychiatric Emergency Services (CAPES), Wilmington Hospital Emergency Department /302-428-2118
 - Crisis Intervention Services, Northern Delaware Hotline / 800-652-2929
- KENT
 - Westside Family Healthcare- 1020 Forrest Ave (Route 8), Dover, DE 19904 / 302-678-4622*
 - Dover Mental Health Center- 805 River Road, Dover, DE 19901 / 302-857-5073
 - LaRed Health Center/Milford – 1 Sussex Avenue, Milford, DE 19963 / 302-855-1233
- SUSSEX
 - LaRed Health Center/Georgetown - 21444 Carmean Way Georgetown, DE 19947 / 302-855-1233*
 - LaRed Health Center/Seaford – 300 High Street, Seaford, DE 19973 / 302-855-1233
 - Georgetown Mental Health Center - 546 S. Bedford Street, Georgetown, DE 19947/ 302-856-5490
 - Recovery Response Center – 700 Main Street, Ellendale, DE 19941 / 302-424-5660

**** See reverse page for HIV services and additional resources****



STATE OF DELAWARE
DEPARTMENT OF CORRECTION
POST RELEASE HEALTH CARE INFORMATION SHEET

Christiana Care HIV Transition 2 Wellness Program

It is important that you continue to receive HIV treatment services after your release. The Discharge Planner can assist you in selecting the best location for you to receive services and will schedule an appointment for you, upon your request.

HIV Community Program: Main Site (Annex)

Wilmington Hospital Annex, 1400 North Washington Street, Wilmington, DE 19801
Phone: 302-320-1300 Fax: 302-320-1374

Porter State Service Center

511 W. 8th Street, Wilmington, DE 19801
Phone: 302-320-1333 Fax: 302-320-1340

Beautiful Gate Outreach Center

604 North Walnut Street, Wilmington, DE 19801-3808
Phone: 302-320-1333 Fax: 302-320-1340

Newark Wellness Clinic at Brandywine Counseling

24 Brook Hill Drive, Newark, DE 19702
Phone: 302-320-1333 Fax: 302-320-1340

HIV Program at Lancaster (Located at Brandywine Counseling)

2713 Lancaster Ave, Wilmington, DE 19805
Phone: 302-504-5967 Fax: 302-656-8569

Georgetown Wellness Clinic Stockley Center

26351 Patriot Way, 102 Lloyd Lane Georgetown, DE 19947
Phone: 302-933-3420 Fax: 302-933-3421

Kent Wellness Clinic Smyrna Home for the Chronically Ill

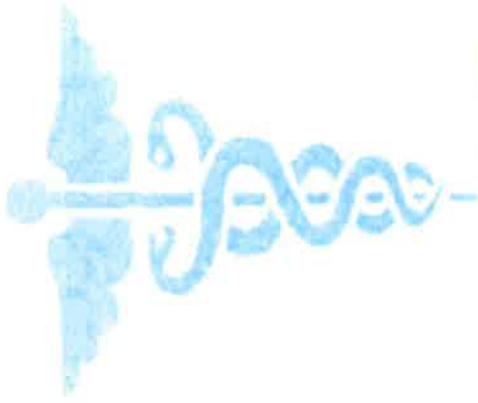
100 Sunnyside Road, Smyrna, DE 19977
Phone: 302-653-1900 Fax: 302-653-1901

Other Resources

- Health & Human Service Information and Referral Line (Non-Emergency): 2-1-1 or www.delaware211.org
- Life- Threatening Emergencies: 9-1-1
- Delaware Assist: www.assist.dhss.delaware.gov / Delaware Social Service Centers
- Partnership for Prescription Assistance / www.pparx.org / 888-477-2669
- Social Security Administration / <http://socialsecurity.gov>
 - New Castle: 900 W. Basin Road, Suite 200, New Castle, DE 19720 / 866-667-7221
 - Kent: 500 W. Loockerman St., Suite 100, Dover, DE 19904 / 877-701-2141
 - Sussex: 12001 Old Vine Blvd., Suite 101, Lewes, DE 19953 / 866-864-1803
- Health Care for Reentry Veterans: 717-272-6621 / 877-424-3838 / 877-222-8387
- Health Insurance Enrollment Hotline: 855-900-9672 / www.HealthCare.com
- Addiction Prevention, Treatment and Recovery: www.helpisherede.com

Delaware Department of
Correction

Delaware Department of Correction



Medical Reentry Resource Guide & Release Plan

**Bureau of Correctional
Healthcare Services
245 McKee Road
Dover, DE 19904**

MLR 2011

Bureau of Correctional Healthcare Services

• 245 McKee Road
Dover, DE 19904

Delaware Department of Correction

Goal:

It is the goal of the Department of Correction (DOC) to support the return of healthy, productive, and crime-free individuals to the community.

To accomplish this goal, the DOC will encourage it's healthcare vendors to work with all designated patients in effective discharge planning.

Please let this booklet serve as your personal plan, and brief Resource Guide, to Services in this State.

Bureau of Correctional Healthcare Services

Your Personal Health Record

Primary Care Doctor (Name, Address, Phone Number):

Alternate Doctor/Specialist (Name, Address, Phone Number):

Alternate Doctor/Specialist (Name, Address, Phone Number):

Dentist (Name, Address, Phone Number):

Eye Doctor (Name, Address, Phone Number):

Emergency Contacts (Name, Address, Phone Number):

Emergency Contacts (Name, Address, Phone Number):

Delaware Department of Correction

Your Personal Health Record

Health Insurance Information:

Living Will/Advance Directives/Medical Power of Attorney:

List significant illnesses/conditions, injuries, and past surgeries:

Allergies/sensitivities to drugs:

Bureau of Correctional Healthcare Services

Your Personal Health Record

Upcoming doctors appointments:

Delaware Department of Correction

Your Personal Health Record

Medications you are taking:

Medication	

Bureau of Correctional Healthcare Services

Resources

Delaware 2-1-1

Delaware Helpline 2-1-1 provides information and referral services through the easy-to-remember three-digit phone number, 2-1-1.

Crisis Hotlines

Mobile Crisis, New Castle County 800-652-2929
 Mobile Crisis, Kent & Sussex Counties 800-345-6785
 Contact Lifeline, Statewide 800-262-9800
 National Suicide Prevention Hotline 800-273-TALK (8255)

Mental Health Assessment

Rockford Center (New Castle County) 302-996-5480
 Dover Behavioral Health (Kent County) 302-741-0140

Mental Health Advocacy, Support, Referrals

National Association on Mental Illness-Delaware (NAMI-DE) 302-427-0787

Mental Health Association in Delaware (MHA) 302-654-6833

Substance Abuse/Mental Health Services

Brandywine Counseling & Community Services 302-656-2348
 Connections CSP 866-477-5345
 Kent Sussex Counseling Services 302-735-7790

Community Mental Health Centers

Wilmington
 1906 Maryland Ave.
 Wilmington, DE 19805 302-778-6900

Claymont

3301 Green St.
 Claymont, DE 19703 302-792-2557

Delaware Department of Correction

Bureau of Correctional Healthcare Services

Community Mental Health Centers

New Castle
14 Central Ave
New Castle, DE 19720
302-255-9450

Newark
501 Ogletown Road
Newark, DE 19711
302-283-7530

Dover
805 River Road
Dover, DE 19901
302-857-5000

Georgetown
546 S. Bedford St.
Georgetown, DE 19947
302-856-5490

Delaware State Service Centers (DSSC)

(The DSSC provide a wide range of health and social service programs.)

Appoquinimink
122 Silver Lake Rd.
Middletown, DE 19709
302-378-5770

Belvedere
310 Kiamensi Rd.
Wilmington, DE 19804
302-995-8545

Claymont
3301 Green St.
Claymont, DE 19703
302-798-2870

DeLaWarr
500 Rogers Rd.
New Castle, DE 19720
302-577-2970

Delaware State Service Centers (DSSC)

Floyd I. Hudson Center
501 Ogletown Rd.
Newark, DE 19711
302-283-7500

Northeast
1624 Jessup St.
Wilmington, DE 19802
302-577-3150

Winder Liard Porter
509 W. 8th Street
Wilmington, DE 19801
302-577-3504

James W. Williams
805 River Rd.
Dover, DE 19901
302-739-5301

Milford Annex
13 S.W. Front St.
Milford, DE 19963
302-422-1650

Milford (Draper Bldg.)
10 Church Ave.
Milford, DE 19963
302-422-1400

Milford (Walnut St. Bldg.)
18 N. Walnut St.
Milford, DE 19963
302-424-7200

Bridgeville
North Cannon and Mill Streets
Bridgeville, DE 19933
302-377-8261

Edward W. Pyle Center
Rt. 4 Box 281-1
Frankford, DE 19945
302-732-9501

Delaware Department of Correction

Delaware State Service Centers (DSSC)

Laurel
440 N. Poplar St.
Laurel, DE 19956
302-875-6943

Thurman Adams
546 S. Bedford St.
Georgetown, DE 19947
302-856-5574

Anna C. Shipley
350 Virginia Ave.
Seaford, DE 19973
302-628-2000

Milford State Service Center
11 - 13 Church Ave.
Milford, DE 19963
302-424-7200

Smyrna State Service Center
200 S. DuPont Blvd.
Suite 101
Smyrna, DE 19977
302-514-4500

AIDS/HIV

HIV Treatment Infoline (National)
AIDS Delaware
Delaware HIV Consortium
Christiana Care Wellness Clinic, Stockley Center
Christiana Care Wellness Clinic, Porter Center
Beautiful Gate Outreach Center
Latin American Community Center
800-822-7422
800-422-0429
302-654-5471
302-933-3420
302-255-1333
302-472-3002
302655-7338

Bureau of Correctional Healthcare Services

Delaware State Service Centers (DSSC)

Veterans Affairs
VA Medical Center
1601 Kirkwood Highway
Wilmington, DE 19805
302-994-2511 or 800-461-8262

Dover Clinic
1198 S. Governors Ave.
Dover, DE 19904
(Same phone numbers as above.)

Georgetown Clinic
15 Georgetown Plaza
Georgetown, DE 19947
(Same phone numbers as above.)

Advocacy and assistance with health insurance, aging, and disability.

Department of Insurance, ELDERinfo Program
(302) 376-4399 in New Castle County, or 1-866-OUR-FCIL

As the State Health Insurance Counseling and Assistance Program (SHIP) for Delaware, ELDERinfo provides counseling and assistance on questions and problems related to Medicare, Medicaid, Medigap, long-term care insurance and other types of health insurance.

Delaware Benefit Information System (DEBIS)

http://www.workworld.org/wwwwebhelp/welcome_and_introduction_deleware_benefit_information_system.htm
(You may use this website to screen for available benefits/resources in Delaware. Internet only.)

Delaware Department of Correction

Advocacy and assistance with health insurance, aging, and disability.

Delaware Division of Services for Aging and Adults with Physical Disabilities (call 800-223-9074)

The mission of the Division of Services for Aging and Adults with Physical Disabilities is to improve or maintain the quality of life for Delawareans who are at least 18 years of age with physical disabilities or who are elderly.

Independent Resources, Inc. (call 302-765-0191 in New Castle County, or toll free from Kent & Sussex Counties at 866-603-6292)

Independent Resources, Inc. is one of two Centers for Independent Living (CILs) in Delaware. CIL's provide a range of services to persons with disabilities, including advocacy, peer support, information and referral, and independent living skills training.

The Arc of Delaware (302-996-9400 (New Castle Co.) · 302-736-6140 (Kent & Sussex Co.))

The Arc of Delaware is a statewide chapter of the Arc of the United States, serving people with intellectual and developmental disabilities and their families.

Medical Transportation

DART First State Paratransit 800-652-3278
(Must complete application and meet eligibility requirements.)

Bureau of Correctional Healthcare Services

Healthcare

Community Healthcare Access Program 800-996-9969

Voluntary Initiative Program. 302-366-1143

Claymont Family Health Services
3301 Green St.
Claymont, DE 19703
302-798-9755

The Center of Hope
Red Mill Shopping Center
1220 Capital Trail
Newark, DE 19711
302-369-9370

St. Clare Medical Van 302-575-8218

Tiny Steps Program (Pre-natal/Maternity)
St. Francis Hospital
7th and Claymont St.
Wilmington, DE 19805
302-575-8040

Westside Family Healthcare
1802 W. 4th St.
Wilmington, DE 19805
302-655-5822

Westside Family Healthcare/Northeast
908-B East 16th Street
Wilmington, DE 19802
302-575-1414

Westside Family Healthcare/Newark
27 Marrows Rd.
Newark, DE 19713
302-455-0900

Westside Family Healthcare/Bear
404 Foxhunt Dr.
Bear, DE 19701
302-836-2864

Delaware Department of Correction

Healthcare

Delmarva Rural Ministries
Kent Community Health Center
640 S. State St.
Dover, DE 19901
302-678-2000

Hope Medical Clinic
1121 Forrest Ave.
Dover, DE 19904
302-735-7551

La Red Health Center
505 W. Market St.
Suite A
Georgetown, DE 19947
302-855-1233

Henrietta Johnson Medical Center
601 New Castle Ave.
Wilmington, DE 19801
302-655-6187

Prescription Assistance

- Prescription discount cards can be used by people, who have no health insurance, for significant savings on prescription drugs.
- Prescription discount cards can also be used, by those who have health insurance, for savings on drugs not covered by their health (or prescription) insurance plan.
- Prices vary from pharmacy to pharmacy. You must use a participating pharmacy in order to receive a discount.
- Some pharmacies may show bigger discounts with one discount card, and lesser discounts, with another card.
- The biggest discounts will be found on generic drugs.
- The best way to determine your biggest discount is to go to the discount card website for pricing information.
- Some cards provide savings on lab and imaging (MRI and CT scans) as well.

Bureau of Correctional Healthcare Services

Healthcare

Prescription Assistance

Recovery Health Network
<http://www.recoveryhealthnetwork.com/>
800-808-1213

RxHope Savings Card
<http://www.rxhopesavings.com/>
877-821-6409

FamilyWize Prescription Discount Card
<http://www.familywize.org/>
800-222-2818

FreeRxPlus
<http://www.rx savings4free.com/>
800-808-1213

RxCardsFree.com (People's Health Express)
<http://www.rxcardsfree.com/rxcardsfree/Home.html>
800-800-7616

Partnership for Prescription Assistance
<http://www.pparx.org/>
(Site provides additional prescription assistance programs.)
888-477-2669

AZ&Mee Prescription Savings Program
<http://www.astrazeneca-us.com/help-affording-your-medicines/prescription-saving-program/>
800-292-6363

Delaware Prescription Assistance Program (DPAP) 800-996-9969
<http://dhss.delaware.gov/dhss/dmma/dpap.html>

Delaware Department of Correction

Resources

Rehabilitation

Delaware Division of Vocational Rehabilitation

The Division of Vocational Rehabilitation is the State's public program that helps people with physical and mental disabilities obtain or retain employment.

Office Locations Statewide

Wilmington

4425 N. Market St.
Wilmington, DE 19802

302-761-8275

Newark

Pencader Corporate Center
225 Corporate Blvd., Suite 204
Newark, DE 19702

302-368-6980

Middletown

Appoquinimink State Service Center
122 Silver Lake Rd.
Middletown, DE 19709

302-378-5779

Dover

Carroll's Plaza, Suite 105
1114 Dupont Highway
Dover, DE 19901

302-739-5478

Georgetown

20793 Professional Park Blvd.
Georgetown, DE 19947

302-856-5730

Bureau of Correctional Healthcare Services

Elements of Medical Reentry

As a Chronic Care Clinic Patient, here are some things you should expect from the Department of Correction and it's medical vendors before your release:

- 1. A Medical Discharge Plan**
Your doctor(s) will work with you to discuss and plan the next steps in the treatment of your Chronic Care Clinic disease.
- 2. A thirty (30) day supply of medication**
At the time of your release, you should be supplied with a 30 day supply of the prescription drugs you are taking . Narcotics, and other controlled drugs, will not be supplied upon release.
- 3. Release of Information (ROI)**
Medical staff will speak with you about the need to sign a Release of Information. It is important to have a current release on file. This will make the transfer of treatment information, from your prison medical file, to your community doctor, quick and easy.

Bureau of Correctional Healthcare Services
245 McKee Road
Dover, DE 19904
302-739-5601

Section III. CREDENTIALLED SCREENER 24-HOUR EMERGENCY DETENTION STATEMENT

I certify that I, _____ am a **Credentialed Mental Health Screener**, # _____
PRINT Full Name / Title

personally assessed that this person, _____
Name of person evaluated D.O.B (mm/dd/yyyy)

MEETS **DOES NOT MEET** the standard for 24-hour detention: experiencing symptoms of mental illness that render this person dangerous to self and/or others by reason of mental condition. (See attached evaluation).

This person was offered voluntary in-patient treatment and:

- is **UNABLE** to self-determine need for treatment.
- REFUSED** voluntary treatment at this date/time: _____ @ _____ : _____ AM / PM
Date (mm/dd/yyyy) Time (hh / mm)
- has **AGREED*** to voluntary treatment. **(If person is now voluntarily agreeing to treatment, please complete page 5 of this form.)*

- I am a Psychiatrist licensed to practice medicine in the state of Delaware.
- I am a licensed Emergency Medicine Doctor and a DSAMH Credentialed Mental Health Screener.
- I am a physician licensed in the state of Delaware to practice medicine or surgery and a DSAMH Credentialed Mental Health Screener.
- I am a Licensed Mental Health Professional or Registered Nurse and also a DSAMH Credentialed Mental Health Screener.
- I am an unlicensed mental health professional, a DSAMH credentialed Mental Health Screener supervised by a psychiatrist.

This person is being taken to: _____
Name of Facility or Address of Alternate Location

I have notified the nearest known relative, _____,
Name of relative / significant other and phone (if different than page 2)

YES **NO** _____
Specify reason not notified

I certify that the information I am providing is true and complete to the best of my knowledge.

Signature Date (mm/dd/yyyy) _____ Time (hh / mm) _____ AM / PM

Title/position Employed by _____ Unit Telephone _____

SECTION IV. CONFLICT of INTEREST STATEMENT

Del. Administrative Code, Title 16, Reg 6002, Sec. 6.1 Conflict of Interest Statement: The intent of the law is to ensure that no person is detained for any reason other than experiencing symptoms associated with a mental condition that may result in danger to self or others, and that any conflicts of interest as set forth in 16 Del.C. §5122 are disclosed on the DSAMH Crisis Intervention Assessment Tool and 24-hour Emergency Admission form filed with DSAMH within 24 hours of signature of the detention order. DSAMH will collect and monitor all assessments, detentions and non-detentions performed by credentialed mental health screeners, whether a conflict of interest is disclosed or not, for purposes of ensuring that the intent of this law is met and that admissions are appropriate.

Conflict of Interest Disclosure Statement: No conflicts Yes, as follows: _____

By my signature, I certify that I have duly disclosed any conflicts of interest and I have made careful inquiry into all the facts necessary for me to form my opinion as to the nature and quality of the person's mental disorder.

Signature Date (mm/dd/yyyy) _____ Time (hh / mm) _____ AM / PM

SECTION V. CHANGE in STATUS

Name of Person being evaluated: _____

D.O.B. ____ / ____ / _____

a. Certification of Understanding:

This section shall only be used if a person who is currently emergently detained requests voluntary admission for inpatient mental health treatment. If a person is found to meet the criteria for voluntary admission pursuant to this section, that person shall have the status of "voluntary" upon arrival at a designated psychiatric treatment facility. A person who is emergently detained shall not have his or her status converted to "voluntary" if the person continues to be a danger to self or danger to others due to an apparent mental condition and such person appears unable or unwilling to remain in care ending the person's placement at designated psychiatric treatment facility. A change in status pursuant to this section shall not be used to discharge a person from care. Only a psychiatrist has the authority to discharge person who is emergently detained.

I have read the above statement and certify that I understand.

Signature

____ / ____ / ____
Date (mm/dd/yyyy)

____ : ____ AM / PM
Time (hh / mm)

Position/ Title

Facility / Hospital

b. Assessment for Voluntary Admission:

I have personally assessed the individual and I certify that the individual has the capacity to fully understand and appreciate the terms of voluntary admission for inpatient mental health treatment, including:

(1) The person will not to be allowed to leave the hospital grounds without permission of the treating psychiatrist

Yes No

(2) If the person seeks discharge prior to the discharge recommended by the person's treatment team, the person's treating psychiatrist may initiate the involuntary inpatient commitment process if the psychiatrist believes the individual presents a danger to self or danger to others

Yes No

(3) Unless the involuntary commitment process is initiated, the person will not have the hospitalization reviewed by the Superior Court

Yes No

If "NO" is selected for any of the above questions the 24-hour emergency detention may not be converted to voluntary admission

(Continue to next page)

Name of Person being evaluated: _____ D.O.B. ____ / ____ / ____

SECTION VII. DISCHARGE: (May ONLY be COMPLETED by a PSYCHIATRIST)

I certify that the above-named individual no longer meets the criteria for emergency detention, for the following reasons:

Signature Date (mm/dd/yyyy) _____ : _____ AM / PM
Time (hh / mm)

Position/ Title Facility / Hospital

Fax copy of this completed form to DSAMH Eligibility and Enrollment Unit during business hours, Mon.-Fri., 7 a.m.-3 p.m. to 302.255.4416.
Outside business hours, please fax to 302.255.9952

This form is to be forwarded to the receiving hospital with the transporting officer or designee.

Section VIII. STATEMENT of PEACE OFFICER or DESIGNATED TRANSPORTER:

I, _____ have transported, _____
with all reasonable promptness, to a designated psychiatric treatment facility, _____,
for further evaluation.

Signature of Officer or Transporter Date (mm/dd/yyyy) _____ : _____ AM / PM
and Time (hh / mm)

Print Full Name Title Unit or Transport Agency Name

Attach Request for Transportation Reimbursement Form, if required.



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

1901 North DuPont Highway, New Castle, Delaware · 19720

Eligibility & Enrollment Unit 302.255.9458 Crisis Intervention Services 800.652.2929

**Fax copy of completed form to DSAMH Eligibility and Enrollment Unit during business hours, Mon.-Fri., 7 a.m.-3 p.m. to 302.255.4416
 or outside business hours, to 302.255.9952**

Instructions: This form is to be completed, signed, and dated for all clients who are being referred for psychiatric services.

Presentation at ED Self Family/Friend Police Provider Other N/A CIS

Referral Source/Relationship _____ Date/Time of Referral _____

On site OR Walk In AND Scheduled OR Unscheduled

Assessment Began _____ a.m. Ended _____ a.m.
 Date (MM/DD/YYYY) and Time (00:00) Date (MM/DD/YYYY) and Time (00:00)

Name of Client _____ Male Female

Street Address _____

City _____

Zip _____

PHONE _____

State/County of Residence Delaware and County: New Castle Kent Sussex Homeless Other State _____

Date of Birth

--	--	--	--	--	--

 Social Sec #

--	--	--	--	--	--	--	--	--	--

Employed YES NO Unknown Occupation _____ Veteran Yes No

Combat? Yes No

Race/Ethnicity African American Asian American Caucasian Native American Other _____ Latin/Hispanic Yes No

Language English Spanish Creole Chinese Other _____ Limited English Proficiency Yes No

Deaf/Hard of Hearing with American Sign Language

Interpreter Needed Yes No

Deaf/Hard of Hearing (does not communicate using ASL)

Medicaid #

--	--	--	--	--	--	--	--	--	--

 INSURANCE Medicare NO INSURANCE

Aetna BC/BS Carve-out Cigna Coventry Diamond State DPCI UHC Tri-Care

Other Insurer _____

DSAMH MH Provider Name: _____ or NONE

ACT ICM CRISP Location/Team _____

Wilmington MHC Dover MHC Georgetown MHC Other or Group Home _____

Provider notified? Yes No N/A Name/Phone# _____

Probation/Legal History/TASC YES NO Unknown (If YES, detail on separate sheet if relevant)

Name of Client _____ DOB _____

Presenting Issues (History of presenting problem, precipitating/participating factors and current systems):

Current Functioning/Behavior Changes related to presenting problem (Note/describe any changes and/or difficulties present in the following areas):

Eating same changed (how) _____

Weight Gain/Loss same changed (how) _____

Sleeping ___hours/night same changed (how) _____

Personal Care same changed (how) _____

Energy same changed (how) _____

Concentration same changed (how) _____

Working / School same changed (how) _____

Family/children/Social same changed (how) _____

Problems associated with addictive behavior (gambling/shopping/Internet/sex) YES NO Unknown

Other functional issues: _____

Marital Status Single Married/Civil Union Separated Divorced Widowed Living With _____

Sexual Orientation: Heterosexual Homosexual Bisexual Transgender Asexual Undisclosed

Recent Stressors: Relationship Family Job Housing Financial Legal Other _____

Health Issues: IDDM NIDDM Hypertension Cardiac HIV Status Hep C Other _____

Special Needs: Wheelchair Oxygen Walker Crutches Cane

Other _____

Medical History/Treatment/Pertinent injuries: (diagnosis/describe) _____

Medical Provider: _____

Behavioral Health History/Treatment

Substance Use History/Treatment

Is there a family history of substance use issues? YES NO Unknown

Does the person currently use mind-altering substances (drugs, alcohol, marijuana, etc.) YES NO Unknown

If yes, what substances

Opiates Cocaine Cannabis Benzos Amphetamines Alcohol Ecstasy Bath Salts PCP

When last used: _____

N/A _____ BAL/Breathalyzer UDS Other: _____

Any past or current treatment for substance use (describe; include dates, include ER meds, and if restraints used):

Mental Health History/Treatment

Is there a family history of mental health issues? YES NO Unknown

(diagnosis/describe) _____

Is there a family history of suicide attempt(s) or completion(s)? YES NO Unknown

(describe) _____

Name of Client _____ DOB _____

Any Past Hospitalizations (date(s), descriptions) _____

Current Treating Psychiatrist YES NO Name/Date last seen _____

Anhedonia Yes No Hopelessness Yes No Self-mutilation Yes No Judgement intact Yes No

Mental Status (Circle all that apply):

Appearance	Neat	Well Groomed	Disheveled	Dirty	Drowsy	Intoxicated	Casual	
Eye Contact	Adequate	Intense	Staring	Avoidant	Guarded	Poor	Other _____	
Speech	Normal	Soft	Loud	Slowed	Slurred	Pressured	Repetitive	
Interaction	Pleasant	Cooperative	Angry	Guarded	Suspicious	Apathetic	Aloof	Passive
Motor Activity	Appropriate	Restless	Hyperactive	Repetitive	Agitated			
Affect	Full Range	Flat	Blunted	Labile	Constricted	Tearful	Inappropriate	
Mood	Calm	Anxious	Depressed	Manic	Hostile	Sad	Euphoric	
Thought Process	Coherent	Goal Directed	Blocking	Loose Associations	Tangential	Word Salad		
Thought Content	Coherent	Suicidal	Homicidal	Hallucinations:	Auditory	Visual	Olfactory	Tactile
	Grandiose	Delusional	Persecutory	Somatic	Jealousy	Religious	Broadcasting	
Orientation	Oriented	Person	Place	Time	Disoriented			

Risk Assessment (Note/describe any difficulties present):

Suicidal: NO Denies current thoughts of self-directed harm and is future oriented OR Passive Thoughts YES NO

Active Recurrent Thoughts YES NO Making Threats YES NO Left Note YES NO

Actionable Plan YES NO Available Weapons/Mean YES NO Currently Attempted YES NO

Command Hallucinations Yes No History of Suicide Attempts YES NO

Details (when/how/what prevented or stopped attempt?) _____

Homicidal Thoughts/Violence: NO Denies current thoughts of other-directed harm. OR Passive Thoughts YES NO

Active Recurrent Thoughts YES NO Making Threats YES NO History of Violence YES NO

Actionable Plan YES NO Access to weapons/means YES NO

Command Hallucinations YES NO Identified target/individual? Duty to Warn? YES NO

Current/history of Violent Behavior NO/Denies YES Details/thoughts/plans _____

Name of Client _____ DOB _____

Comments on Risk/Safety Plan: _____

Trauma History: _____

Diagnostic Impression: _____

Current Medications:

Prescriber: PCP Specialist Psychiatrist

Drug/Dosage _____

Drug/Dosage _____

Drug/Dosage _____

Disposition/Plan:

Home with Referrals _____

Home with WBC/WBV If Yes Start Date _____ End Date _____ Was authorization to leave message obtained? Yes No

Outpatient Treatment Referrals _____ Crisis Bed

Hospitalization Voluntary Involuntary _____

Other/Describe _____

Referral Sheet Signed? Yes No If No Why not? _____

Release of Information Signed? Yes No If Yes For Whom/Agency _____

Del. Administrative Code, Title 16, Reg 6002, Sec. 6.1 Conflict of Interest Statement: The intent of the law is to ensure that no person is detained for any reason other than experiencing symptoms associated with a mental condition that may result in danger to self or others, and that any conflicts of interest as set forth in 16 Del.C. 55122 are disclosed on the DSAMH Crisis Intervention Assessment Tool and 24-hour Emergency Admission form filed with DSAMH within 24 hours of signature of the detention order. DSAMH will collect and monitor all assessments, detentions and non-detentions performed by credentialed mental health screeners, whether a conflict of interest is disclosed or not, for purposes of ensuring that the intent of this law is met and that admissions are appropriate.

Conflict of Interest Disclosure Statement:

No conflicts Yes, as follows: _____

By my signature, I certify that I have duly disclosed any conflicts of interest and I have made careful inquiry into all the facts necessary for me to form my opinion as to the nature and quality of the person's mental disorder.

Signature _____ Date _____ and _____ Time _____

Print Name/Title/Unit _____ Telephone _____


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

1901 North DuPont Highway, New Castle, Delaware 19720

Eligibility & Enrollment Unit 302.255.9458

PSYCHIATRISTS' CERTIFICATE FOR PROVISIONAL HOSPITALIZATION* (Civil Commitment)

Fax copy of completed form to DSAMH Eligibility and Enrollment Unit during business hours, Mon.-Fri., 7 a.m.-3 p.m. to **302.255.4416**
or outside business hours, to **302.255.9952**

REVIEWING PSYCHIATRIST: Please complete EITHER the Admission or the Discharge Statement, attach documentation and sign the bottom of the form.

CERTIFICATE for PROVISIONAL HOSPITAL ADMISSION (to be completed for persons being referred for inpatient evaluation).

I certify that on _____, _____^{a.m.}
Date (mm/dd/yy) Time (00:00) p.m. at _____
Location

I have carefully examined _____
Name Date of Birth (mm/dd/yyyy)

of _____
Street Address City State Zip

and corroborate the certified Mental Health Screener's finding him/ her to have met the standard for mental illness as well as dangerousness to self or others, therefore requiring involuntary provisional admission and immediate care or treatment.

I offered this person voluntary in-patient treatment and

- this person is unable to self-determine need for treatment.
 this person refused voluntary treatment.

Based on above, I have begun the involuntary commitment process as set forth in Title 16, Chapter 50 of the Delaware Code by recommending involuntary provisional admission.

This person is is not capable of waiving procedural rights, including retention of

- counsel,
 psychiatrist or
 other qualified medical expert to testify on his/her behalf at the court hearing.

(If financial assistance is required to retain counsel or other expert, please complete certification of financial need on page 2)

The required request for court hearing has has not been filed as required within 48 hours of provisional admission.

I offered this person voluntary in-patient treatment and

- this person has accepted a voluntary offer of in-patient treatment and
_____ I certify that this is the least restrictive, most appropriate level of care given this person's symptoms.
Initial

NOTIFICATION OF RIGHTS

_____ I certify that I have this day delivered to the above-named client a copy of 16 Del. C., Sec 5161,
Initial "Rights of Patients in Hospitals for the Mentally Ill," and other rights set forth in Title 16.

I acknowledge that I have received this information. _____
Signature of Client Date Time

- This person refused to sign acknowledgment.

(*Pursuant to Del. Code Title 16 §5003. Request for Court Hearing to be filed within 48 hours. Del.Code Title 16 §5007)

Del. Administrative Code, Title 16, Reg 6002, Sec. 6.1 Conflict of Interest Statement: The intent of the law is to ensure that no person is detained for any reason other than experiencing symptoms associated with a mental condition that may result in danger to self or others, and that any conflicts of interest as set forth in 16 Del.C. §5122 are disclosed on the DSAMH Crisis Intervention Assessment Tool and 24-hour Emergency Admission form filed with DSAMH within 24 hours of signature of the detention order. DSAMH will collect and monitor all assessments, detentions and non-detentions performed by credentialed mental health screeners, whether a conflict of interest is disclosed or not, for purposes of ensuring that the intent of this law is met and that admissions are appropriate.

Conflict of Interest Disclosure Statement:

No conflicts Yes, as follows: _____

By my signature, I certify that I have duly disclosed any conflicts of interest and I have made careful inquiry into all the facts necessary for me to form my opinion as to the nature and quality of the person's mental disorder. (psychiatrist must sign and print name).

Signature Date and Time

Print Name/Title/Unit Telephone

Certification of Financial Ability to Retain Private Medical, Psychiatric and/or Legal Representation

Based upon financial information obtained from client other informant: _____
Name and Relationship

this person can afford to retain legal counsel YES NO can afford to retain a psychiatrist or other qualified medical expert YES NO.

Name of Guarantor (if private legal/psychiatric/medical representation is to be retained) Telephone Number

Street Address City State Zip

The client respectfully prays the court to appoint and assume financial responsibility for the services of legal counsel psychiatrist/medical expert.

Financial Resource Examiner Name and Date Psychiatric Facility Official Signature and Date

(Fax copy of completed form to DSAMH's Eligibility and Enrollment Unit (302) 255-4416)

DISCHARGE STATEMENT (to be completed for persons for whom further evaluation can be completed in the community, if necessary, or who have consented to seek treatment voluntarily.)

I certify that on _____ a.m. / p.m. at _____
Date (mm/dd/yy) Time (00:00) Location

I have carefully examined _____
and

I find this person has NOT met the standards of "A person who has a mental illness and is likely to be in danger of hurting him or herself, or others, and to require immediate care, treatment, or detention." (Give a description of the behavior and symptoms)

AND/OR

The person is capable of voluntarily consenting to in-patient care or other less-restrictive treatment as required.

Describe/justify (summarize attached examination findings):

Describe disposition plans that were provided to this person upon discharge:

(Please attach other forms or documents to support your findings)

Del. Administrative Code, Title 16, Reg 6002, Sec. 6.1 Conflict of Interest Statement: The intent of the law is to ensure that no person is detained for any reason other than experiencing symptoms associated with a mental condition that may result in danger to self or others, and that any conflicts of interest as set forth in 16 Del.C. §5122 are disclosed on the DSAMH Crisis Intervention Assessment Tool and 24-hour Emergency Admission form filed with DSAMH within 24 hours of signature of the detention order. DSAMH will collect and monitor all assessments, detentions and non-detentions performed by credentialed mental health screeners, whether a conflict of interest is disclosed or not, for purposes of ensuring that the intent of this law is met and that admissions are appropriate.

Conflict of Interest Disclosure Statement:

No conflicts Yes, as follows: _____

By my signature, I certify that I have duly disclosed any conflicts of interest and I have made careful inquiry into all the facts necessary for me to form my opinion as to the nature and quality of the person's mental disorder. (psychiatrist must sign and print name).

Psychiatrist's Signature Date

Print Full Name Email

Practice Address Phone Number

Your Search...



Phone Numbers Mobile Help Size Print Email

Delaware Health and Social Services » Division of Substance Abuse and Mental Health

HOME

SERVICES

INFORMATION

- Training
- Medical Library
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- Regulations
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- Residency
- Publications & Forms
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I. Clinical Eligibility Determination

The Division of Substance Abuse and Mental Health (DSAMH) LTC system serves adults (age 18 years and older) with severe and persistent behavioral health disorders who meet disability, duration of illness and diagnostic criteria. The LTC System provides services for: individuals enrolled in Medicaid; individuals with dual eligibility of Medicaid and Medicare; individuals with Medicare only coverage; individuals without insurance coverage; and those with limited insurance coverage.

Clinical eligibility for and enrollment into the DSAMH Long Term Care (LTC) system will be determined by the DSAMH Eligibility and Enrollment Unit (EEU). The EEU will process all applications for enrollment into the DSAMH LTC System.

Clinical Eligibility Criteria for Enrollment into the DSAMH LTC System

- are age 18 years and older; and
- are U.S. citizens or have a legal resident alien status; and
- are residents of the State of Delaware; and
- are determined to have a specific primary DSM-IV diagnosis as listed below (Eligible Mental Illness Diagnoses and Eligible Substance Abuse Diagnoses) that has resulted in functional impairment which substantially interferes with or limits one or more major life activities [as determined by a formal DSAMH EEU review of the clinical information submitted in a complete [Enrollment Application Form](#)]; and
- present a history of having received intensive behavioral health treatment in one or more community or institutional programs including: Delaware Psychiatric Center; DSAMH Continuous Treatment Team programs; group homes, and long-term residential substance abuse treatment facilities; and/or
- present a history of having had multiple alcohol and other drug detoxification admissions and/or multiple intensive substance abuse treatment episodes.

Special eligibility determinations will be made for adults with developmental disabilities/mental retardation who have a severe and persistent behavioral health disorder and are in the upper mild range of mental retardation (317.0).

All individuals meeting the clinical eligibility criteria will be enrolled in the DSAMH LTC system.

Eligible Mental Illness Diagnoses

Schizophrenia and Other Psychotic Disorders

Code	Diagnosis
295.10	Disorganized Type
295.20	Catatonic Type
295.30	Paranoid Type
295.40	Schizophreniform Disorder
295.60	Residual Type
295.70	Schizoaffective Disorder
295.90	Undifferentiated Type
297.10	Delusional Disorder

Mood Disorders

Major Depressive Disorder, Recurrent

Code	Diagnosis
-------------	------------------

296.30	Unspecified
296.32	Moderate
296.33	Severe Without Psychotic Features
296.34	Severe With Psychotic Features

Bipolar Disorders**Code Diagnosis**

296.40	Bipolar I Disorder, Most Recent Episode Hypomanic
296.50	Bipolar I Disorder, Most Recent Episode Manic
296.60	Bipolar I Disorder, Most Recent Episode Mixed, Unspecified
296.70	Bipolar I Disorder, Most Recent Episode Unspecified
296.80	Bipolar Disorder NOS
296.89	Bipolar Disorder II

Personality Disorders**Code Diagnosis**

301.00	Paranoid Personality Disorder
301.22	Schizotypal Personality Disorder
301.83	Borderline Personality Disorder

Eligible Substance Dependence Diagnosis**Substance Dependence Diagnosis****Code Diagnosis**

303.90	Alcohol Dependence
304.00	Opioid Dependence
304.10	Sedative, Hypnotic or Anxiolytic Dependence
304.20	Cocaine Dependence
304.80	Polysubstance Dependence
304.90	Other (or unknown) Substance Dependence; Phencyclidine Dependence

Clinical Eligibility Exclusions

DSAMH LTC services will not be available for:

- Adults with DSM-IV diagnoses not listed as eligible. Adults with the following DSM-IV developmental disabilities/mental retardation diagnoses: 318.0 (Moderate Mental Retardation); 318.1 (Severe Mental Retardation); 318.2 (Profound Mental Retardation); and 319.0 (Mental Retardation, Severity Unspecified); and
- Adults with DSM-IV diagnoses not listed as eligible.

Requests for a clinical eligibility determination should be submitted on a consumer's/client's behalf by any Managed Care Organization (MCO) participating in the Diamond State Health Plan (DSHP) or by a behavioral health provider currently treating the consumer/client. The referral process will remain the same for all organizations submitting a request for a clinical eligibility determination and enrollment. The documentation for a clinical eligibility determination is independent from the financial eligibility determination for Medicaid, Medicare and other third party insurance liability. Financial eligibility determination for Medicaid will be performed by the DHSS/Division of Social Services (DSS).

The requesting MCO or behavioral health organization must provide full documentation regarding medical necessity when applying for a consumer's/client's clinical eligibility determination for and enrollment in the DSAMH LTC system. This will include full documentation regarding the consumer's/client's utilization of behavioral health services prior to the request for clinical eligibility determination.

The requesting organization must complete the Enrollment Application Form and submit it to the Director of the EEU. The requesting organization will ensure that all information needed to make a timely decision for a clinical eligibility determination will be provided to the EEU. In addition to submitting the Enrollment Application Form, the requesting organization must designate a Clinical Liaison to serve as a point of contact regarding issues of referral.

The EEU will review the referral packet for completeness and quality. Incomplete packets will be returned to the referring organization for completion within one (1) working day of DSAMH's receipt of the incomplete application.

Upon receipt of a complete referral packet, the EEU will evaluate the clinical documentation provided, complete an **Eligibility Determination Review** and make a determination as to the consumer's/client's eligibility for the DSAMH LTC system within one (1) working days of receipt of the complete application.

The EEU will provide written notification to the referring organization and the consumer/client of the results of its eligibility determination within one (1) working days of the review's completion. Notification to the referring organization will include a copy of the **Eligibility Determination Summary**.

Some of the files above are in Adobe Acrobat format. You can view them with Adobe Acrobat Reader. For your free copy please visit [Acrobat](#)



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**DELAWARE DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH
DSAMH BEHAVIORAL HEALTH INTENSIVE SERVICE SYSTEM**

ELIGIBILITY DETERMINATION REVIEW

ENROLLMENT APPLICATION FORM

**DSAMH ELIGIBILITY AND ENROLLMENT UNIT
Susan McLaughlin, Director (Acting)
1901 North DuPont Highway
New Castle, DE 19720**

**302/255-9461 (voice)
302/255-4416 (fax)
Susan.McLaughlin@state.de.us**

EEU APPLICATION FOR SERVICES

(Section 1) Demographics and Status Request

Today's Date: _____

Consumer Last name (print): _____ First: _____ MI.: _____

SS#: _____ DOB: _____ Age: _____

Gender Expression: ___ (M) ___ (F) Marital Status: _____ Ethnicity: _____

TASC Client: Yes ___ No ___ Unknown ___ Probation Officer: _____

MCI # _____ (if known) Source and Amount of Income: _____

Medicaid #: _____ Medicare # _____ Other Insurance (specify): _____

Current Residence (type): _____

Indicate whether the applicant lives in a private residence (supervised or unsupervised), Adult Foster Care, Boarding House, Group Setting (supervised or unsupervised), psychiatric inpatient facility (provide name), Nursing Home (specify), other Institutional Setting (specify), homeless or other (explain)

Current Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Person to Contact in Case of an Emergency: _____

Address: _____

Telephone Number: _____ Relationship: _____

Primary Language: () English () Spanish () American Sign Language () Other: _____

Does the enrollee have a guardian? ___(no) _____(yes/specify)

Does the enrollee have a representative payee? ___(no) _____(yes/specify)

LOC Requested: (e.g., ICM or ACT or SUD residential, etc.) _____

Current LOC and Provider: _____

Application completed by: (print) _____ (signature) _____

Referring Agency: _____ Phone/ext.: _____ FAX #: _____

FOR MH SERVICES ATTACH A RECENT (within last 6 months) PSYCHIATRIC EVALUATION WHICH INCLUDES THE INDIVIDUALS DIAGNOSTIC PROFILE

*** Psychiatric evaluation must be signed by the individual completing the evaluation**

Psychiatrist or Psychiatric Prescriber who performed the evaluation and formulated the diagnosis:

(Print Name)

Phone #: _____ Date of Diagnosis: _____

(Section 2)

A. What is the most important thing the client wants or made the client decide to call or come in for help right now? "What is most important to you that you would like help with right now?" Document what the client wants, not what you as the clinician believes the client should be working on.

B. ASAM Dimensions: Provide a brief narrative for each dimension that explains your Rating of Severity/Function. Focus on brief relevant **history** information and relevant **here and now** information. CHECK ALL ITEMS THAT APPLY

Dimension 1: Acute Intoxication and/or Withdrawal Potential - Substance Use: Include Amount, Duration and Last Use for each substance (except "no known risk," explain any item checked)

- No known risk
- Adequate ability to tolerate/cope with intoxication or withdrawal symptoms
- Some difficulty tolerating/ coping with intoxication or withdrawal discomfort
- Past history of complicated withdrawal needing medical intervention
- Current potential for complicated withdrawal needing medical intervention
- Use is current and complicated withdrawal needing medical intervention is imminent

Dimension 2: Biomedical conditions/complications (except "no known," explain any item checked)

- No known biomedical conditions/complications
- Current physical illnesses exist, and are: stable unstable acute (circle as appropriate)
- There is a history of chronic conditions

Dimension 3: Emotional/Behavioral/Cognitive Conditions or Complications:

SUICIDALITY (except "no history," explain any item checked)

- No history or current suicidal ideation
- Has frequent passive thoughts of being better off dead
- Exhibits suicidal ideation without a plan
- Exhibits suicidal ideation with a plan
- Has recently attempted suicide or made credible threats with a plan and means
- Has a history of suicidal gestures or threats

EEU APPLICATION FOR SERVICES

SELF-CONTROL/IMPULSIVITY (except "no history," explain any item checked)

- Has no history of self-control/impulsivity issues
 - Is involved with the judicial or legal system
 - Has been arrested for alcohol- or drug-related crimes, or for use/possession/distribution of drugs, for minor theft, destruction of property, vagrancy/loitering, disturbing the peace, or public intoxication within the past 6 months
 - Currently experiencing problems related to gambling
 - Has a history of arrests for illegal or unsafe activities
-
-

DANGEROUSNESS (except "no known history," explain any item checked)

- Has no known history of dangerousness
 - Lacks impulse control/control of violent behavior
 - Has a history of violent or dangerous social behavior
 - Exhibits inappropriate or dangerous social behavior dangerous to others, e.g. physical or sexual assault, fire setting
 - Engages in behavior dangerous to himself/herself
 - Engages in behavior dangerous to property
 - Engages in behavior that leads to victimization
-
-

SELF-CARE (except "no self-care deficits," explain any item checked)

- No self-care deficits noted
 - Does not seek appropriate treatment/supportive services without assistance or requires significant oversight to do so; needs services to prevent relapse
 - Requires assistance in basic life and survival skills (i.e. locating food, finding shelter)
 - Requires assistance in basic hygiene, grooming and care of personal environment
 - Engages in impulsive, illegal or reckless behavior
 - Experiences frequent crisis contacts (____ (number) within ____ (number) months)
 - Experiences frequent detoxification admissions (____ (number) within ____ (number) months)
-
-

PSYCHIATRIC/EMOTIONAL HEALTH (except "does not exhibit signs/symptoms," explain any item checked)

- Does not exhibit signs/symptoms of psychiatric or emotional illness
- Psychiatric symptoms are well managed with medication/treatment
- Symptoms persist in spite of medication adherence
- Psychiatric symptoms and signs are present and debilitating
- Experiences delusions and/or hallucinations which interfere with client's ability to function
- Acute or severe psychiatric symptoms are present which seriously impair client's ability to function
- Currently taking medications for these symptoms (list below)
- Medication adherence is inconsistent
- Experiences mood abnormality (depression, mania)
- Is frequently very anxious or tense
- Is unable to appropriately express emotions
- Experiences hopelessness, apathy, lack of interest in life
- Experiences physical symptoms related to their psychiatric illness or addiction (e.g. sleeplessness, stomach aches)
- Lacks any sense of emotional well-being

EEU APPLICATION FOR SERVICES

PSYCHIATRIC/EMOTIONAL HEALTH/continued

Current medications and dosages. You may attach a copy of your Medication Administration Record (MAR) or order sheet if it is legible.

Medication	Dosage	Effectiveness
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Allergies: _____

Dimension 4: Readiness to Change:

UNDERSTANDING OF ILLNESS AND RECOVERY (explain any item checked)

- Exhibits understanding of the nature of his/her mental health and/or substance use illness and/or physical health and its effects
- Exhibits some understanding of the nature of his/her mental health and/or substance use illness and/or physical health and its effects
- Little or no understanding of the nature of his/her mental health and/or substance use illness and/or physical health and its effects
- Limited understanding of the nature of his/her mental health and/or substance use illness and/or physical health and its effects
- Does not have an understanding of his/her illness(es) and recovery

DESIRE TO CHANGE (explain any item checked)

- States desire to change
- Indicates some desire to change
- Limited desire or commitment to change
- Doesn't understand the need to change
- Relates to treatment with some difficulty and establishes few, if any trusting relationships
- Does not use available resources independently or only in cases of extreme need
- Does not have a commitment to recovery

EEU APPLICATION FOR SERVICES

Dimension 5: Relapse, Continued Use, Continued Problem Potential:

CURRENT AND PREVIOUS TREATMENT HISTORY AND RESPONSE (explain any item checked)

- Takes medication with good response/complete remission of symptoms
- Takes medications (with or without assistance) as prescribed with continued symptoms/partial remission of symptoms
- Not using but no behavioral changes to support recovery
- Not taking prescribed medications with a history of violence
- Previous or current treatment has not achieved remission of symptoms
- Previous treatment exposures have been marked by minimal effort or motivation and no significant success or recovery period was achieved
- Attempts to maintain treatment gains have had limited success
- Has had extensive and intensive treatment
- Has had some treatment
- This is the first treatment
- Court ordered to treatment ____ (civil) ____ (criminal)

Treatment Service history. Include all inpatient and outpatient treatment. We are particularly interested in the past 24 months or since last placement summary. If more space is needed, attach additional page(s).

DATES		PROVIDER	Effectiveness (treatment goals met, premature discharge before goals met; problems encountered)
FROM	TO		

RELAPSE PREVENTION, ILLNESS MANAGEMENT AND COPING (explain any item checked)

- Has awareness of relapse triggers and ways to cope with MH breakthrough symptoms and/or substance use cravings
- Has some awareness of relapse triggers and ways to cope with MH breakthrough symptoms and/or substance use cravings
- Is unaware of relapse triggers and ways to cope with mental health breakthrough symptoms and/or substance use cravings
- Lacks skills to control impulses to use or harm self or others
- Doesn't follow medication regimen
- Requires assistance and/or support to actively manage relapse prevention
- Tolerates organized daily activities or environmental changes
- Exhibits some tolerance for organized daily activities or environmental changes
- Has little tolerance for organized daily activities or environmental changes
- Is unable to tolerate organized daily activities or environmental changes (e.g. activities or changes cause agitation, exacerbation of symptoms or withdrawal)
- Is unable to cope with stressful circumstances associated with work, school, family or social interaction
- Lack of resilience in response to stress

EEU APPLICATION FOR SERVICES

Dimension 6: Recovery Environment:

RECOVERY ENVIRONMENT: (except "safe affordable housing of own choosing," explain any item checked)

- Resides in safe affordable housing of own choosing
- Resides in safe affordable housing but is not of own choosing
- Resides in licensed Adult Foster Care
- Resides in unlicensed Adult Foster Care
- Resides in a Group Home
- Resides in Supervised Housing/Apartment
- Living arrangement puts client at risk of harm
- Living environment increases client's stress
- Unable to or only marginally able to support themselves in independent housing
- At risk of eviction due to behavioral health problems
- At risk of homelessness for other reasons (e.g. family refuses to allow a return to the home, community complaints...)
- Homeless
- There is serious disruption of family or social milieu due to illness, death, severe conflict, etc.
- Estranged from their family
- Significant difficulties in interacting with family members
- Lacks ability to provide food for self or dependent children
- No transportation
- No child care presenting a barrier to participate in treatment
- Language barriers interfere with full participation in treatment
- Resides in environment where easily victimized
- Other

INTERPERSONAL/SOCIAL FUNCTIONING (explain any item checked)

- Has several close relationships or group affiliations
- Has one or two close relationships or group affiliations
- Lacks connections to supportive social systems in the community
- Unable to form close friendships or group affiliations
- Unable to interact appropriately with family and/or the community
- Unable to engage in meaningful activities
- Is socially isolated
- Is in abusive relationship(s)

Client Strengths that will help him/her be successful at this level of care:

Possible Barriers to treatment:

Psychosocial Assessment Form
DOC & CCHS HIV Program

Inmate Name:
Date of Birth:
SBI#:

Attachment K

DOC/CCS: Please complete this form prior to release and include with records you are sending for patient's appointment at CCHS site.

Gender: Male Female Transgendered MTF Transgendered FTM Unknown

Race: Black or African American White Asian American Indian or Alaska Native
 Native Hawaiian or other Pacific Islander Other _____ Unknown Multi-racial

US Citizen: Yes No **State of Residency** _____

Ethnicity: Hispanic Non-Hispanic Unknown

Date of HIV Test _____ (If tested in prison/jail)

Living Situation: Stable/Permanent Non-Permanent Institutional
 Unstable Unknown/Unreported

Marital Status: Single Married Domestic Partner Divorced Widowed
 Separated Co-habiting (significant other) Other _____

Insurance: Is patient insured? Yes No Pending **Type of insurance** _____

If no, has patient applied? Yes No **Date** _____

If No insurance, is patient: Eligible for Medicaid Eligible for CHAP Over Income

Date referred for: CHAP/Medicaid: _____

Source of income: None Employment Unemployment SSI/SSDI SS Retirement
 GA Other _____

Mental Health: History (age, diagnosis, treatments, psychiatric hospitalizations and/or rehabilitation, outcomes, psychosocial adjustments):

Past use of psychotropic medication: Yes No

Current use of psychotropic medication: Yes No **List Meds:** _____

Substance Use; Is there a history of drug/alcohol use? Yes No If yes, drug of choice: _____

Crest Program? YES NO (circle one)

Legal: Do you have any current legal issues/hearings? _____

Date most recent incarceration & release date: _____

Reason _____

Location of most recent incarceration _____

How many times has patient been incarcerated? _____

Parole/Probation/Crest: release plan; probation/parole officer (name and telephone number)

Signature _____ **Date/Time** _____