**Section 117.APPENDIX B Eligibility determination forms**

**Section 117.ILLUSTRATION A DMHDD-1237.2, Eligibility Determination – Primary Examiners – Adults with a Severe Mental Illness**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Illinois Department of Human Services | | | | | | | | | | | | |
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| ELIGIBLITY DETERMINATION – PRIMARY EXAMINERS  – ADULTS WITH A SEVERE MENTAL ILLNESS | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| Name of applicant: | | | |  | | | | | | | | |
| Date of examination: | | | | |  | | | | | | | |
|  | | | | | | | | | | | | |
|  | I verify that I am a | | | | |  | | | | board eligible/certified psychiatrist | | |
|  |  | | | | |  | | | | licensed clinical psychologist | | |
|  | and that the above–named individual was evaluated personally by me. | | | | | | | | | | | |
|  | | | | | | | | | | | | |
|  | I verify that I have found the person to meet the eligibility criteria for determination as an Adult with a Severe Mental Illness | | | | | | | | | | | |
|  |  | | | | | | | | | | | |
|  | I verify that I have found the person does not meet the eligibility criteria for determination as an Adult with a Severe Mental Illness. | | | | | | | | | | | |
|  |  | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| I have attached my evaluation and copies of any other evaluations used by me in making this determination. | | | | | | | | | | | | |
|  | | | Name (type or print) | | | | | | | |  |  |
|  | | | Signature | | | |  | | | | |  |
|  | | | Address | | | | |  | | | |  |
|  | | |  | | | | |  | | | |  |
|  | | |  | | | | |  | | | |  |
|  | | | License no. | | | | | |  | | |  |
|  | | |  | | | | | | | | | |
| Return in self-addressed, stamped envelope or send to: | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
|  | | Department of Human Services | | | | | | | | | | |
|  | | Home-Based Support Services Program | | | | | | | | | | |
|  | | Room 405 Stratton Building | | | | | | | | | | |
|  | | Springfield IL 62765 | | | | | | | | | | |

**Section 117.APPENDIX B Eligibility determination forms**

**Section 117.ILLUSTRATION B DMHDD-1237.2, Eligibility Determination – Primary Examiners – Children with Severe Emotional Disturbance**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Illinois Department of Human Services | | | | | | | | | | | |
|  | | | | | | | | | | | |
| ELIGIBLITY DETERMINATION – PRIMARY EXAMINERS  – CHILDREN WITH A SEVERE EMOTIONAL DISTURBANCE | | | | | | | | | | | |
|  | | | | | | | | | | | |
| Name of applicant: | | | |  | | | | | | | |
| Date of examination: | | | | |  | | | | | | |
|  | | | | | | | | | | | |
|  | I verify that I am a | | | | |  | | | board eligible/certified psychiatrist | | |
|  |  | | | | |  | | | licensed clinical psychologist | | |
|  | and that the above–named individual was evaluated personally by me. | | | | | | | | | | |
|  | | | | | | | | | | | |
|  | I verify that I have found the person to meet the eligibility criteria for determination as a Child with a Severe Emotional Disturbance. | | | | | | | | | | |
|  |  | | | | | | | | | | |
|  | I verify that I have found the person does not meet the eligibility criteria for determination as a Child with a Severe Emotional Disturbance. | | | | | | | | | | |
|  |  | | | | | | | | | | |
|  | | | | | | | | | | | |
| I have attached my evaluation and copies of any other evaluations used by me in making this determination. | | | | | | | | | | | |
|  | | | Name (type or print) | | | | | | |  |  |
|  | | | Signature | | | |  | | | |  |
|  | | | Address | | | |  | | | |  |
|  | | |  | | | |  | | | |  |
|  | | |  | | | |  | | | |  |
|  | | | License no. | | | | |  | | |  |
|  | | | | | | | | | | | |
| Return in self-addressed, stamped envelope or send to: | | | | | | | | | | | |
|  | | | | | | | | | | | |
|  | | Department of Human Services | | | | | | | | | |
|  | | Home-Based Support Services Program | | | | | | | | | |
|  | | Room 405 Stratton Building | | | | | | | | | |
|  | | Springfield IL 62765 | | | | | | | | | |

**Section 117.APPENDIX B Eligibility determination forms**

**Section 117.ILLUSTRATION C DMHDD-1237.3, Eligibility Determination – Primary Examiners – Children and Adults with Severe Autism**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Illinois Department of Human Services | | | | | | | | | | | |
|  | | | | | | | | | | | |
| ELIGIBLITY DETERMINATION – PRIMARY EXAMINERS  – CHILDREN AND ADULTS WITH A SEVERE AUTISM | | | | | | | | | | | |
|  | | | | | | | | | | | |
| Name of applicant: | | | |  | | | | | | | |
| Date of examination: | | | | |  | | | | | | |
|  | | | | | | | | | | | |
|  | I verify that I am a | | | | |  | | | board eligible/certified psychiatrist | | |
|  |  | | | | |  | | | licensed clinical psychologist | | |
|  | and that the above–named individual was evaluated personally by me. | | | | | | | | | | |
|  | | | | | | | | | | | |
|  | I verify that I have found the person to meet the eligibility criteria for determination as Children and Adults with a Severe Autism. | | | | | | | | | | |
|  |  | | | | | | | | | | |
|  | I verify that I have found the person does not meet the eligibility criteria for determination as Children and Adults with a Severe Autism. | | | | | | | | | | |
|  |  | | | | | | | | | | |
|  | | | | | | | | | | | |
| I have attached my evaluation and copies of any other evaluations used by me in making this determination. | | | | | | | | | | | |
|  | | | Name (type or print) | | | | | | |  |  |
|  | | | Signature | | | |  | | | |  |
|  | | | Address | | | |  | | | |  |
|  | | |  | | | |  | | | |  |
|  | | |  | | | |  | | | |  |
|  | | | License no. | | | | |  | | |  |
|  | | | | | | | | | | | |
| Return in self-addressed, stamped envelope or send to: | | | | | | | | | | | |
|  | | | | | | | | | | | |
|  | | Department of Human Services | | | | | | | | | |
|  | | Home-Based Support Services Program | | | | | | | | | |
|  | | Room 405 Stratton Building | | | | | | | | | |
|  | | Springfield IL 62765 | | | | | | | | | |

**Section 117.ILLUSTRATION D DMHDD-1237.4, Eligibility Determination – Primary Examiners – Children and Adults with Severe or Profound Mental Retardation**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Illinois Department of Human Services | | | | | | | | | | | |
|  | | | | | | | | | | | |
| ELIGIBLITY DETERMINATION – PRIMARY EXAMINERS – CHILDREN AND ADULTS WITH A SEVERE OR PROFOUND MENTAL RETARDATION | | | | | | | | | | | |
|  | | | | | | | | | | | |
| Name of applicant: | | | |  | | | | | | | |
| Date of examination: | | | | |  | | | | | | |
|  | | | | | | | | | | | |
|  | I verify that I am a | | | | |  | | | licensed clinical psychologist | | |
|  |  | | | | |  | | | certified school psychologist | | |
|  | and that the above–named individual was evaluated personally by me. | | | | | | | | | | |
|  | | | | | | | | | | | |
|  | I verify that I have found the person to meet the eligibility criteria for determination as Children and Adults with a Severe or Profound Mental Retardation. | | | | | | | | | | |
|  |  | | | | | | | | | | |
|  | I verify that I have found the person does not meet the eligibility criteria for determination as Children and Adults with a Severe Profound Mental Retardation. | | | | | | | | | | |
|  |  | | | | | | | | | | |
|  | | | | | | | | | | | |
| I have attached my evaluation and copies of any other evaluations used by me in making this determination. | | | | | | | | | | | |
|  | | | Name (type or print) | | | | | | |  |  |
|  | | | Signature | | | |  | | | |  |
|  | | | Address | | | |  | | | |  |
|  | | |  | | | |  | | | |  |
|  | | |  | | | |  | | | |  |
|  | | | License no. | | | | |  | | |  |
|  | | | | | | | | | | | |
| Return in self-addressed, stamped envelope or send to: | | | | | | | | | | | |
|  | | | | | | | | | | | |
|  | | Department of Human Services | | | | | | | | | |
|  | | Home-Based Support Services Program | | | | | | | | | |
|  | | Room 405 Stratton Building | | | | | | | | | |
|  | | Springfield IL 62765 | | | | | | | | | |

**Section 117.APPENDIX B Eligibility determination forms**

**Section 117.ILLUSTRATION E DMHDD-1237.5, Eligibility Determination – Primary Examiners for Children and Adults with Severe and Multiple Impairments**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Illinois Department of Human Services | | | | | | | | | | | |
|  | | | | | | | | | | | |
| ELIGIBLITY DETERMINATION – PRIMARY EXAMINERS  – CHILDREN AND ADULTS WITH SEVERE AND MULTIPLE IMPAIRMENTS | | | | | | | | | | | |
|  | | | | | | | | | | | |
| Name of applicant: | | | |  | | | | | | | |
| Date of examination: | | | | |  | | | | | | |
|  | | | | | | | | | | | |
|  | I verify that I am a | | | | |  | | | board eligible/certified psychiatrist | | |
|  |  | | | | |  | | | licensed clinical psychologist | | |
|  |  | | | | |  | | | licensed physician | | |
|  | and that the above–named individual was evaluated personally by me. | | | | | | | | | | |
|  | | | | | | | | | | | |
|  | I verify that I have found the person to meet the eligibility criteria for determination as Children and Adults with a Severe and Multiple Impairments. | | | | | | | | | | |
|  |  | | | | | | | | | | |
|  | I verify that I have found the person does not meet the eligibility criteria for determination as Children and Adults with a Severe and Multiple Impairments. | | | | | | | | | | |
|  |  | | | | | | | | | | |
|  | | | | | | | | | | | |
| I have attached my evaluation and copies of any other evaluations used by me in making this determination. | | | | | | | | | | | |
|  | | | Name (type or print) | | | | | | |  |  |
|  | | | Signature | | | |  | | | |  |
|  | | | Address | | | |  | | | |  |
|  | | |  | | | |  | | | |  |
|  | | |  | | | |  | | | |  |
|  | | | License no. | | | | |  | | |  |
|  | | | | | | | | | | | |
| Return in self-addressed, stamped envelope or send to: | | | | | | | | | | | |
|  | | | | | | | | | | | |
|  | | Department of Human Services | | | | | | | | | |
|  | | Home-Based Support Services Program | | | | | | | | | |
|  | | Room 405 Stratton Building | | | | | | | | | |
|  | | Springfield IL 62765 | | | | | | | | | |