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

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

|  |
| --- |
| Illinois Department of Human Services |
|  |
| 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**

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| Illinois Department of Human Services |
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| 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 |