Milwaukee County Comprehensive Community Services (CCS)
Determination of Need Statement

Name: Click here to enter text.	Functional Screen Eligibility Date:Click here to enter a date.
MRN: Click here to enter text.	Is this an Abbreviated Assessment? : ☐ Yes ☐ No

There is an existing diagnosis of a
MENTAL DISORDER:
☐ Yes ☐ No
DSM Diagnosis:

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There is an existing diagnosis of a
SUBSTANCE USE DISORDER:
☐ Yes ☐ No
DSM Diagnosis:

____

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Does this Consumer have a functional impairment that limits one or more major life activities and results in a need for services that are described as ongoing, comprehensive and either high-intensity or low-intensity?

☐ **Yes** ☐ **No**

☐ **Meets "Group 1" Criteria**: Persons in this group include children and adults in need of ongoing, high-intensity, comprehensive services who have a diagnosed major mental disorder or substance-use disorder, and substantial needs for psychiatric, substance abuse, or addiction treatment.

☐ **Meets "Group 2" Criteria**: Persons in this group include children and adults in need of ongoing, low-intensity comprehensive services who have a diagnosed mental or substance-use disorder. These individuals generally function in a fairly independent and stable manner but may occasionally experience acute psychiatric crises

Eligible

☐ The applicant meets the CCS eligibility requirements and is determined to need psychosocial rehabilitation services.

☐ The applicant is not eligible for CCS due to: See details below.

Ineligible

☐ The applicant is determined to NOT need psychosocial rehabilitation services.

☐ The applicant does not qualify under the program exceptions. See consumer's Discharge Letter for more details.

Milwaukee County ensures that no participant is denied benefits or services or is subjected to discrimination on the basis of age, race or ethnicity, religion, marital status, arrest or conviction record, ancestry, national origin, disability, gender, sexual orientation or physical condition.
I have reviewed the applicant's need for psychosocial rehabilitation services and attest to this determination.

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Mental Health Professional:

____

Print Name & Credentials:
Click here to enter text.

____

Date: ______________________

Substance Abuse Professional (*if applicable*):

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Print Name & Credentials:
Click here to enter text.

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Date: ______________________