

Kentucky Checklist for the Identification of Co-Occurring Behavioral Health and Chronic or Complex Physical Health Condition

Individual's Name _____

Identification Number _____

Diagnostic Code(s) _____

The following table illustrates the criteria that shall be met for an individual to be designated as qualifying for targeted case management for co-occurring Behavioral Health (SMI, SED, SUD) and a Chronic or Complex Physical Health Condition(s).

YES	NO	CRITERIA
		<p>Designation of Behavioral Health Conditions (Check all that apply):</p> <p style="text-align: center;">SED _____, SMI _____, SUD _____</p> <p style="text-align: center;">as determined and documented by a licensed behavioral health professional on _____.</p> <p style="text-align: center;">Date</p>
YES	NO	<p>2. Chronic or Complex Physical Health Conditions: Means that <i>significant symptoms of a physical health condition have persisted in the individual for a continuous period of at least two (2) years, or that the individual has been hospitalized as a result of this physical health condition for more than once in the last two (2) years, AND</i></p> <p>a) That the <i>symptoms of the physical health condition presently significantly impair the individual in his/her ability to function socially, educationally/occupationally, or both.</i></p> <p>b) Physical Health Conditions: For the purposes of this regulation, these physical health conditions may include disorders under the following categories:</p> <ul style="list-style-type: none"> a. Cardiovascular Disorders b. Respiratory Disorders c. Genito-Urinary Disorders d. Endocrine Disorders e. Musculoskeletal Disorders f. Neurological Disorders g. Immune System Disorders h. Gastrointestinal Disorders i. Hematological Disorders <p><i>Note: Documentation of the existence of these criteria is present in the individual's medical record (documented and signed/dated behavioral health assessment has been conducted by a qualified, licensed behavioral health professional) and with the Physical Health diagnosis (documented and signed/dated has been made by a qualified medical professional).</i></p>

Print Name/Credentials _____

Signature _____

Date _____