PRIME TIME CAREER SERVICES ELIGIBILITY GUIDE

ELIGIBILITY:

A) Individuals 18 years of age or older who are currently receiving DMHAS services through other DMHAS funded programs, i.e. CHD or Mental Health of CT residential services. (relationship should be noted on the Notice of Interest form)

B) Individual 18 years of age or older who received Supported Employment Services from Prime Time previously which should be noted on the Notice of Interest form.

C) Individuals 18 years of age or older with:

* an AXIS I diagnosis of a severe and prolonged mental illness which impacts their ability to obtain or maintain employment
* a history of psychiatric hospitalizations

An addendum which includes the necessary clinical information cited above (*) should be completed by a clinician inclusive of the clinician's contact information and attached to the Notice of Interest form along with the appropriate Release of Information.

WHO SHOULD BE REFERRED:

- Individual who expresses a desire to get a job in the very near future (active job development occurs within 30 days of entering the program)
- Individual who expresses a need for support in maintaining a job or progressing in their career

HOW DO YOU MAKE A REFERRAL:

1) Complete the Notice of Interest form with the individual

2) If including additional clinical information, complete an appropriate Release of Information form for WCMHN-DA Supported Employment Program Manager to determine DMHAS eligibility. If eligibility is denied or there are further questions in relation to eligibility, the WCMHN-DA Supported Employment Program Manager will reach out to the clinician.

Submit the Notice of Interest form, and when necessary the appropriate Release of Information form and clinical summary, to the embedded Employment Specialist who will then submit all the appropriate documentation to the WCMHN-DA Supported Employment Program Manager for review.

Western Connecticut Mental Health Network
Supported Employment & Supported Education Services
Notification of Interest

☐ Supported Employment *(forward directly to Employment Specialist assigned to team.)*

☐ Supported Education *(forward to the WCMHN local area office for utilization management.)*

If interested in receiving both services, make a copy of the completed form & forward as instructed above.

1. **Individual Expressing Interest**

Name: ______________________________ **Date:** ____________

2. **Statement of Interest**

Why, in his/her own words, is the individual interested in participating in Supported Employment or Education?

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3. **Additional Information**

- Is the Individual authorized to work in the United States? (U.S. Citizen or Green Card) ☐ Yes ☐ No
- Is the individual currently active in the service system? ☐ Yes ☐ No
- Does the individual have a conservator? ☐ Yes ☐ No
- Current MGAF Score: _________ Highest MGAF in the Past Year: ________

4. **Benefits** (provide approximate monthly amounts)

SSI _________ SSDI ____________ TANF ______________ W/C ___________ VA ____________

Title XIX ___________ SAGA _______________ Other _____________ No Benefits ______________

5. **Team Assignment** Is the interested person on a WCMHN-operated Team? ☐ Yes ☐ No

If YES, attach a copy of the Face sheet in lieu of the information below. Complete an ***AUTHORIZATION TO OBTAIN AND DISCLOSE PROTECTED HEALTH INFORMATION*****.** Forward these as directed above.

If NO, complete sections below. Forward form and a completed release of information form as directed above.

6. **Demographic and Diagnoses Update**

DOB: ________________________ **Social Security Number:**______________________

Address:______________________________

Phone #: _______________ Gender:______ Martial Status: ______ Race:________ Hispanic Y/N: _______

Language: ________ Religion: ____________ Living Situation: ____________ Employment Status: _________

Diagnoses Axis I ______________________________

Diagnoses Axis 2 ______________________________

7. **Primary Clinician/Case Manager**

Name: ______________________________ Agency:____________________

Address: ______________________________ Phone #: _________________

Fax#: __________________________ Email: __________________________

8. **Emergency Contact**

Name: ______________________________ Relationship:____________________

Address: ______________________________ Phone #: _______________________