

Baker Act Service Eligibility

Public Receiving Facility Name: _____

1. IDENTIFYING INFORMATION: Person's Name: _____ Date of Birth: _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Race: _____	
2. FINANCIAL INFORMATION: Prospective monthly income (6-month average) \$ _____ Number of Family Members: _____ Title XX Eligible: <input type="checkbox"/> Yes <input type="checkbox"/> No	
3. LEGAL STATUS: <input type="checkbox"/> Voluntary Admission <input type="checkbox"/> Involuntary Examination	
4. CRITERIA: (check the appropriate criteria) <input type="checkbox"/> There is reason to believe the above-named person has a mental illness, as defined in 394.455(18), AND <input type="checkbox"/> Without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself, such neglect or refusal poses a real and present threat of substantial harm to his or her well-being, and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services, OR <input type="checkbox"/> There is a substantial likelihood that without care or treatment the person will cause serious bodily harm to himself or herself or others in the near future, as evidenced by recent behavior.	
5. MOST RECENT DSM OR ICD ADMISSION DIAGNOSIS AND CODE NUMBER: _____	
6. SUMMARY: Behavioral manifestations justifying diagnosis. (A completed CF-MH 3052a or 3052b or Ex Parte Order may be attached for persons on involuntary status)	
7. RECOMMENDED DISPOSITION / PLACEMENT:	
8. WHY IS A LESS RESTRICTIVE PLACEMENT NOT BEING UTILIZED?	
9. APPROVAL OF DISPOSITION/PLACEMENT <input type="checkbox"/> does <input type="checkbox"/> does not include authorization for payment of contracted 24-hour care.	

Signature of Administrator or Designee

Date

Time

_____ am pm

Printed Name of Administrator or Designee