State of Montana – Clinical Eligibility for Mental Health Services Plan

Transmit the information below to AMDD Benefit Management Team

FAX: 1-406-444-4435
Phone: 1-406-444-3964

Mail: Addictive and Mental Disorders Division
PO Box 202905
Helena MT 59620-2905

Please Type or Print:

CLIENT INFORMATION		
Date of intake appointment:	**Referred by:**	
SSN:	**DOB:**	**Gender:**
Name: Last:	**First:**	**Middle:**
Mailing Address:		**City and State:**
County:	**Zip:**	**Telephone #:**
Client's stated reason for seeking services:		
PROVIDER INFORMATION		
Agency Name:	**Clinician email address:**	
Agency Address:		**City:**
Zip:	**Telephone No:**	**Fax #:**
CLINICAL INFORMATION		
CURRENT DSM-IV DIAGNOSES: Please list both code and narrative, including substance use disorders.		
Axis I : (Primary*)		
Axis II:		
Axis III : (specify)		
Axis IV: (specify)		
Axis V: (GAF)		
***List Signs / Symptoms to Substantiate the Qualifying SDMI Primary Diagnosis:**		
Name of Medication:	**Dose/Frequency:**	**Prescriber:**

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Name: Last ______________________________ **First:** _________________________

If no current medications, has a medical professional with prescriptive authority determined that medication is necessary to control the symptoms of the mental illness? Yes ☐ No ☐

Name and title of medical professional:

History of Adult Outpatient Mental Health Treatment: Yes ☐ No ☐
Please list any services in which the individual has participated, including individual &/or family therapy.

History of Inpatient Adult Mental Health (NOT CD) Treatment: Yes ☐ No ☐

Number of Acute Psych Admissions:	**Date of most recent admission:**
Number of State Hospital Commitments:	**Date of most recent commitment:**

Reason for most recent admission:

Is the individual unable to work full time due to mental illness? Yes ☐ No ☐
If yes, briefly describe:

Is the individual unable to live independently due to mental illness? Yes ☐ No ☐
If so, briefly describe:

Is the individual homeless or at risk of homelessness due to mental illness? Yes ☐ No ☐
If yes, briefly describe:

Has the individual applied to the Social Security Administration for disability due to mental illness?
Yes ☐ No ☐ Status / Outcome of application:

Current Risk Factors (e.g. suicidal ideation/plan, danger to others, history of abuse impacting current functioning):

Proposed Treatment Plan (identify services, i.e. medications, CM, OPT, etc.):

"I certify that I am the person who performed face-to face clinical assessment and the above statements are true and current."

Provider Signature:____________________________________ Title: ______________________________

Printed Name:_______________________________________ Date: ______________________________

Supervisor Signature:_________________________________ Date: ______________________________
(if applicable)

AMDD Use Only: SDMI: YES: ___ NO: ___ ENROLL:___ WAIT:___

Reviewed By:____ Date: _________________