Addictive and Mental Disorders Division (AMDD)
Severe and Disabling Mental Illness (SDMI)
Home and Community Based Services (HCBS) Waiver

Clinical SDMI Eligibility Request

All forms must be typed. Handwritten or incomplete forms will be returned.

Request Date: ________________________

Requester Information

CMT Team Name: _____________________________________CMT Name: ___________________________________
Address: _______________________________________ City: __________________________ Zip: _________________
Phone #: ______________________________ Cell #: __________________________ Fax #: _______________________

Demographics

Member Name: _______________________________ Birthdate: ________________Medicaid #:___________________
Address: _______________________________________ City: __________________________ Zip: _________________
Phone #: ______________________________ Cell #: __________________________ SS #: ________________________

Does the member have a legal guardian/power of attorney? ☐ Yes ☐ No

Guardian Name: _______________________________ Relationship to Member: ________________________________
Address: _______________________________________ City: __________________________ Zip: _________________
Phone #: ______________________________ Cell #: __________________________

Brief Description of Request

Current SDMI Diagnosis: _________________________ ICD-10: ________________ Current LOI Score: ______________

Stipulation Needed? ☐ Yes ☐ No

Send Completed Form to
AMDD Secure Fax: (406)444-4436
File Transfer to Barbara Graziano at bgraziano@mt.gov
Do not send PHI or HIPPA protected information through email

Office Use Only

☐ Approved ☐ Denied Date: __________________ Completed by: ___________________________________

Brief Description of Rational: