State of Montana
Clinical Eligibility Assesment for Mental Health Services Plan

Transmit the information below to AMDD Benefit Management Team

FAX: 1-406-444-7391

Phone: 1-406-444-3964

Mail: c/o AMDD
PO Box 202905
Helena MT 59620-2905

Please Type or Print:

CLIENT INFORMATION		
SSN:	**DOB:**	**Gender:**
Name: Last:	**First:**	**Middle:**
Mailing Address:		**City:**
County:	**State: MT**	**Zip:**
Telephone No:		
RESPONSIBLE PARTY INFORMATION, if other than client		
Name: Last:	**First:**	**Middle:**
Mailing Address:		
City:	**State:**	**Zip:**
Telephone No:	**Relationship to client:**	
PROVIDER INFORMATION		
Provider Name:	**Provider No:**	
Address:		
City:	**State:**	**Zip:**
Telephone No:	**Fax No:**	
CLINICAL INFORMATION		
CURRENT DSM-IV DIAGNOSES: **Please list code and narrative, including substance use disorders.**		
Axis I : (Primary)		
Axis II:		
Axis III : (specify)		
Axis IV: (specify)		
Axis V: (GAF)		

Processing may be delayed if information submitted is <u>illegible</u> or <u>incomplete.</u>

Name: Last _____ First: _____
SSN: _____

List Signs / Symptoms to Substantiate the Qualifying SDMI Primary Diagnosis:	
Current Psychotropic Medications: Yes ☐ No ☐	
Name of Medication:	**Dose/Frequency**
If none, 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:	
Has the individual been determined to be disabled due to mental illness by the Social Security Administration? Yes ☐ No ☐	
History of Outpatient Mental Health Treatment: Yes ☐ No ☐ Please list any services in which the individual has participated, other than individual &/or family therapy.	
History of Inpatient Mental Health Treatment: Yes ☐ No ☐	
Number of Acute Admissions:	
Date of most recent admission:	
Number of Montana State Hospital Commitments:	
Date of most recent commitment:	
Has the individual participated in Substance Abuse/Dependency Treatment? Yes ☐ No ☐	
Provider, if known:	

Processing may be delayed if information submitted is illegible or incomplete.

State of Montana
Clinical Eligibility Assesment for Mental Health Services Plan

Name: Last _____ **First:** _____
SSN: _____

Is the individual unable to work full-time because of mental illness? Yes ☐ No ☐ **If yes, briefly describe:**
Is the individual able to live independently? Yes ☐ No ☐ **If not, briefly describe:**
Is the individual homeless or at risk of homelessness? Yes ☐ No ☐ **If yes, briefly describe:**

Risk Factors:

(check all that apply)	**Present**	**Past**
Domestic Violence	☐	☐
Suicidal Ideation	☐	☐
Sexual Abuse	☐	☐
Eating Disorder	☐	☐
Evidence of Psychosis	☐	☐
Threat to Others (homicidal ideation)	☐	☐

"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)

Addictive & Mental Disorders Division Use Only:

Reviewed By:_____ Date: _____

SDMI: APPROVED: _____ DENIED: _____

Processing may be delayed if information submitted is illegible or incomplete.