

**FAX TO: MOUNTIAN PACIFIC QUALITY HEALTH FAX #: 1-800-497-8235 OR (513-1927 – (Helena))**

**SDMI HOME AND COMMUNITY BASED SERVICES  
INTAKE SHEET**

Individual's Name: _____	
(Last Name)	(First Name)
Individual's Medicaid ID #: _____	Case Management Team No.: _____
Admit Date: _____	Readmit Date: _____
Pay Status: _____ Medicaid	_____ Medically Needed

<p><b>RESIDENTIAL STATUS PRIOR TO HCBS: (Circle One)</b></p> <p>1. <b>Institution</b>                   (1) <b>Nursing Facility</b>   (2) <b>State Institution</b></p> <p>2. <b>Private Residence</b>           (1) <b>Lives Alone</b>   (2) <b>Lives with Parents or Adult Children</b>   (3) <b>Lives with Spouse</b>   (4) <b>Shared Living with Relatives</b>   (5) <b>Shared Living with Non-relatives</b></p> <p>3. <b>Group Residence</b>           (1) <b>Adult Residential</b>   (2) <b>Group Home</b>   (3) <b>Retirement Home</b></p> <p>4. <b>Acute Care Hospital</b>       (1) <b>From Nursing Facility</b>   (2) <b>From Private Residence</b>   (3) <b>From Group Residence</b></p>	<p><b>CARE CATEGORY: (Check One)</b></p> <p>3. _____ <b>Hospital (CC3) <i>Not applicable</i></b></p> <p>4. _____ <b>Nursing Facility (CC1 &amp; CC2) <i>Not applicable</i></b></p> <p>5. _____ <b>Big Sky Bonanza Independence Plus (CC4) <i>Not applicable</i></b></p> <p>6. _____ <b>SDMI Waiver</b></p>
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**SERVICES AUTHORIZED: (Check all that apply)**

_____ Adult Day Care	_____ Wellness Recovery Action Plan (WRAP)
_____ Adult Residential	_____ Prevocational Services
_____ Case Management	_____ Private Duty Nursing
_____ Chemical Dependency Counseling	_____ Psychosocial Consultation
_____ Illness Management Recovery (IMR)	_____ Registered Nurse Supervision
_____ Day Habilitation	_____ Residential Habilitation
_____ Habilitation Aide	_____ Respite Care
_____ Homemaker	_____ Specialized Medical Equipment
_____ Homemaker Chore	_____ Specialized Medical Supplies
_____ Nutrition (meals)	_____ Specially Trained Attendants
_____ Nutritional Counseling	_____ Supported Employment
_____ Occupational Therapy	_____ Supported Living
_____ Personal Assistance Services	_____ Transportation

_____	_____
Signature	Date