

MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

MONTANA MENTAL HEALTH NURSING CARE CENTER

(406) 538-7451
FAX (406) 535-2863

800 CASINO CREEK DRIVE
LEWISTOWN, MONTANA 59457

To Whom It May Concern:

The Montana Mental Health Nursing Care Center is a 100 bed licensed residential facility for long-term care and treatment. The residents here have mental disorders and require a level of care not available in the community. Mental disorders are defined as any organic, mental or emotional impairment, which has substantial adverse effects on an individual's cognitive or volitional functions.

To be eligible for admission a person must:

- A. Be in need of long-term nursing care
- B. Have a mental disorder
- C. Meet the following criteria:
 1. Exhibit behaviors rendering the person unable to be served appropriately in the community of residence, or in a less restrictive setting, including a non-specialized nursing home.
 2. Does not require acute medical hospital care or active psychiatric treatment as provided by Montana State Hospital.
 3. Does not require the services of a full-time psychiatrist.
 4. Has received a comprehensive medical evaluation within 60 days prior to application.
 5. Has received a mental health evaluation and recommendation for admission by a mental health professional person within 60 days prior to application.
 6. Complete a Center Application for Admission.
 7. Is admitted on a voluntary basis by the person, a legally appointed guardian, or durable power-of attorney providing for health care decisions, or by a valid order of commitment from a district court issued pursuant to Title 53, Chapter 21, Montana Code Annotated.

Patients from Montana State Hospital who meet the above criteria will be given priority for admission to the Center.

This facility Prohibits Discrimination on the Basis of Race, Color, Sex, Age, Handicap, Religion or National Origin.

**The Center is a Tobacco Free Campus.
No Tobacco products, lighters or matches allowed on grounds.**

Please complete the attached admissions application form. If you have questions or require additional information, feel free to contact the Admissions Coordinator at (406) 538-7451

*A Residential Facility for the Long-Term Care and Treatment of Persons who have a mental disorder
An Equal Opportunity Employer*



Department of Public Health and Human Services
Montana Mental Health Nursing Care Center
 800 Casino Creek Drive
 Lewistown Montana 59457
 Phone (406) 538-7451 Fax (406) 535-2863

Application for Involuntary Admission

Name of Applicant:	Date of Birth:
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status:
Legal Guardian/DPOA/POA: Address:	Phone:
Referring Facility or County of Initial Commitment:	
Address:	
Contact Person:	Phone:
Specific Behavior Issues Causing Referral:	

Attempted Placement Documentation:

Facility	Date of Referral	Date of Denial	Reason for Denial

In order to process your admission application, please include the following:

- **History and Physical (completed within the last 60 days)**
- **Nursing Assessment: (to include but not limited to)**
 - *Nursing Notes (past month)
 - *Activities of Daily Living
 - *Current Medications
- **Psychiatric History and Current Evaluation**

Signature of Person Completing Application:
Printed Name:
Title/Position:
Address:
Phone:

Fax Applications to: Montana Mental Health Nursing Care Center
Attn.: Jan Spoonheim
Fax (406) 535-2863

Call with any questions: (406) 538-7451

Department of Public Health and Human Services

Montana Mental Health Nursing Care Center
800 Casino Creek Drive
Lewistown Montana 59457
Phone (406) 538-7451 Fax (406) 535-2863

Welcome to the Montana Mental Health Nursing Care Center.

Upon your acceptance, please provide the following information:

- **Current Medications**
- **Doctors' Orders, including dietary orders**
- **Vaccination/Immunization/PPD history/Chest X-Ray**
- **Nursing Assessment: (to include but not limited to)**
 - *Nursing Notes (most current from time of application)
 - *Current Treatment/Care Plan
- **Social History**
- **Labs (past 3 months)**
- **Commitment Order from the Court**
- **Advanced Directives/POLST**
- **Guardian/DPOA/POA paperwork (if applicable)**
- **Representative Payee/Conservator Contact Information (if applicable)**
- **Family Contact Information**
- **Copies of Birth Certificate and/or Social Security Card**
- **Copies of Insurance cards (necessary)**
 - **INSURANCE INFORMATION:** *Please attach a legible copy of any insurance cards*

Medicare ID#	Effective Dates: A B
Medicare D Plan:	Member ID#:
Medicaid #:	Effective Date:
Other Insurance	
Plan Name:	Member ID#:
Address:	Group #:

• **FINANCIAL STATUS-SOURCES OF INCOME AND AMOUNTS**

SSI \$	VA \$	Retirement \$ Source
SSDI \$	Service Connected %:	
SS \$		
Tribal \$	Other \$	
Tribe:	Source	