72-HOUR CRISIS STABILIZATION PROGRAM
Addictive and Mental Disorders Division - State of Montana

FAX COVER SHEET

DATE Submitted: _____

TO:AMDD Benefit Management Team
Telephone: 406-444-3964 Fax: 406-444-7391

FROM: Crisis Care Manager: _____

Telephone: _____ Fax: _____

Email: _____

RE: 72-Hr Crisis Stabilization Program

pages (including cover): _____

Instructions:

Please complete the following two pages, and fax or email to the AMDD Benefit Management Team, using this page as the cover sheet.

Reimbursement is available only for the services/codes listed on the form.

ONLY USE FOR 72 HOUR CRISIS STABILIZATION – This form would be used for hospitals and any crisis home where more than 24 hours are spent.

THIS FORM MUST BE SUBMITTED WITHIN 60 DAYS OF ADMISSION TO CRISIS STABILIZATION SERVICES
This form cannot be processed if the information submitted is illegible or incomplete. **June 2018**

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CLIENT INFORMATION

LAST NAME:		**FIRST NAME:**	
ADDRESS:		**CITY:**	**ZIP CODE:**
SSN:	**D.O.B.:**	**COUNTY:**	**GENDER**: ☐M ☐F
Marital Status: ☐ Single	☐ Married	☐ Separated/Divorced	☐ Domestic Partnership
Race/Ethnicity: ☐ Caucasian	☐ Native American	☐ Hispanic	☐ Black ☐ Unknown

PROVIDER INFORMATION

Date of Service:

Mental Health Practitioner Name: Telephone Number:

Crisis Stabilization Agency / Facility Name: City:

Telephone Number: Fax Number:

ELIGIBILITY ASSESSMENT

Does this individual's situation meet the definition of Crisis: ☐ **Yes** ☐ **No**
If yes - Please specify:

Referral for Crisis Stabilization services made by:

☐ Ambulance / EMT	☐ Self	☐ Hospital ER / ED
☐ Family / Friend	☐ Homeless Shelter	☐ Probation / Parole / Prerelease
☐ Law Enforcement	☐ Nursing Home	☐ Crisis Facility / Program

☐ Jail (please specify):

☐ **Other please specify location of contact**:

THE INDIVIDUAL IS: ☐ **AT RISK TO SELF** ☐ **AT RISK TO OTHERS**

BECAUSE OF THESE SYMPTOMS & BEHAVIORS

☐ Agitated/Aggressive	☐ Florid Mania	☐ Suicidal -Means/plan/Intent
☐ Delusions	☐ Hallucinations	☐ **Other (please specify):**
☐ Disoriented	☐ Homicidal	

OTHER FACTORS: ☐ Domestic Violence ☐ Homeless ☐ Under the influence of alcohol / drugs

Suspected substance(s):

PRESENTING ISSUE

☐ Mental Health Issue ☐ Substance Abuse ☐ Co-occurring

Describe presenting issue:

Mental Health Practitioner Signature & Credentials: _____

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CRISIS STABILIZATION PLAN	
Problems:	**Interventions:**
Strengths/Resources/Natural Supports:	

DISCHARGE INFORMATION			
Was this individual the client of a mental health service provider or agency at the time of this crisis? ☐ Yes ☐ No			
Referred to Provider/Agency:		**Date of appointment:**	
☐ Client refused referrals	Prescriptions given at discharge: ☐ Yes ☐ No	☐ Client refused medication	
Written information provided to (please specify information given and to whom):			
☐ Client:		☐ Family/friend:	
☐ Community Supports (i.e., 12 step, religious/spiritual):			
☐ Other (i.e., MD, MHC, OPT, Detention Officer, etc.):			
DISCHARGED FROM 72 HR PROGRAM TO:			
☐ Acute Inpatient Psychiatric Unit	☐ Home	☐ Homeless Shelter	☐ **Other (please specify):**
☐ Crisis Stabilization Program	☐ Family / friend	☐ Montana State Hospital	
☐ Client left crisis stabilization services against medical advice.			

The following information will be used to authorize reimbursement.

CRISIS STABILIZATION SERVICES PROVIDED			
Service Begin Date/Time:		**service End Date/Time:**	
PROFESSIONAL SERVICES	**Code**	**Units**	**Providing Practitioner's Name**
Care Coodination	H2011		
CRISIS MANAGEMENT SERVICES		**Agency / Facility Name:**	
Crisis Management Hours	**Code**	**Date**	**# of Hours**
Hours 1 - 24	S9484 U1		
Hours 25 - 48	S9484 U2		
Hours 49 - 72	S9484 U3		

Crisis Care Manager Signature: _____ **Date:** _____

Print Form Save Form Reset Form

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