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: