St. Clair County Community Mental Health

General Fund Support Services Request

Individual: ________________________________ Case #: ______________________ Date Request Initiated: _______________

Select that Apply: ☐ ID/DD ☐ SMI ☐ SUD ☐ SED
Select One: ☐ Child (Under 18) ☐ Adult (18 & Older)
Insurance Type(s): ☐ Medicaid/HMP ☐Medicare ☐ Spenddown ☐ Private ☐ VA ☐None

Note: All sections on this page must be completed prior to submission or form will be returned.

What are the services being requested? Please list the specific code(s), number of units, and timeframe for each unit.

____
____

Length of Request: ☐ 3 Months ☐ 6 Months ☐ 12 Months ☐ Other: _____________ **Starting Date: ______________**

Reason for Request:

____
____

Is there imminent risk of hospitalization if services are denied? If yes, explain below. ☐ Yes ☐ No

____
____

Is there need for this service/support reflected by a goal or objective in the IPOS? ☐ Yes ☐ No ☐ N/A – New to Services

IPOS Date: __________________ ☐ N/A (New to Services) **Goal #(s):** ___________________

What other supports have been tried?

____
____

Community agencies/resources (Identify by agency)?

____
____

Natural Supports:

____
____

Was Medicaid applied for? ☐ Yes ☐ No

If **Yes,** when was it applied for? _______________________ What is the current status? _________________________

If **No,** an application will be submitted by the following date: ___________________________

Was an Advance Beneficiary Notice of Non-Coverage (ABN) (#0275) filled out? ☐ Yes ☐ No

Individual's Liability: Cost per Session: $____________ Monthly Max Liability: $________________

_______________________________	_______________________________	___________
Case Holder Signature	Print Name	Date
_______________________________	_______________________________	___________
Supervisor Signature	Print Name	Date

DIVISION DIRECTOR APPROVAL

Date Received: ______________________

I have reviewed this request and it: ☐ Does ☐ Does Not **meet the criteria for CMH Services.**

I recommend: ☐ Approval ☐ Denial **for the General Fund.**

☐ Approval, but with Modifications to Auth(s) as described below

Comments:

____

____

_______________________________________ _______________________________________ ____________

Division Director Signature   Print Name   Date

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If Approved,

- Case Holder is to add authorizations to current location and include authorized services in the objectives/interventions in the IPOS.