

**INDIVIDUALS AUTHORIZED TO SIGN
COMMUNITY SUPPORT MEDICATION ENROLLMENT FORM**

Mental Health Center or State Mental Health Hospital: _____

Please note: Only individuals listed on this form will be considered for “authorizing” enrollment in the Community Support Medication Program.

CMHC/SMHH staff authorized to sign Community Support Medication Enrollment/Disenrollment:
(Please print or type)

<u>Name</u>	<u>Title</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Submission of these names affirms that the individuals listed have read the Community Support Medication guidelines and are familiar with both the clinical and financial eligibility guidelines and regulations of the program.

Signature of CMHC Executive Director or SMHH Superintendent

Date

Please fax this form to:
1) Chellie Ortiz, Operations Manager
KIPS
785-228-3951
2) Diana Marsh
SRS, Mental Health
785-296-6142

For PNK Use Only:

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