

COMMUNITY SUPPORT MEDICATION PROGRAM ENROLLMENT APPLICATION

Patient Name _____ Date of Birth _____

SSN _____ Effective Date: _____

Name of Pharmacy to call: _____ Pharmacy Phone No. _____

Medication(s) to be covered: _____ Diagnosis: _____

Justification for Need:

Clinical:

1. SMI (meets criteria for serious mental illness) OR SED (meets criteria for serious emotional disturbance)
2. AND clinically requires the atypical anti-psychotic and/or anti-depressant medication(s) listed above

At-risk:

In the absence of the prescribed medication(s) listed above the individual is at risk for (check all that apply):

- Inpatient psychiatric services
 Intervention by law enforcement
 Out-of-home placement,
 Homelessness
 Institutionalization

Financial:

- A. Income 200% or less than the current federal poverty level,
 B. AND lack medical insurance covering the above specified medication(s),
 C. AND been denied acceptance into an indigent drug program. **List the indigent drug programs that denied acceptance:** _____

OR

- Eligible for Medicaid but currently on Spend down: **Start Date:** _____ **End Date:** _____

OR

- Special circumstance requiring approval through the ? 858G Mental Health Community Support Medication Program Manager [Explain in area below]

Mental Health Center assignment: _____

Authorized signature _____ Date _____

Authorized Individual Name _____ Phone: _____ [for questions/clarification]

Fax Number _____

<p>Fax enrollment form to: Chellie Ortiz Prescription Network Operations Director (785) 228-3951</p>	<p>For ? 858G Use Only:</p> <p style="text-align: center;"> <input type="checkbox"/> Approved <input type="checkbox"/> Not Approved </p> <hr/> <p>? 858G CSMP Manager</p> <hr/> <p>Date _____</p>
<p>Facsimile Confidentiality Statement: The information transmitted by this fax is intended only for the addressee and may contain confidential and/or privileged material. Any interception, review, retransmission, dissemination, or other use of, or taking of any action upon this information by persons or entities other than the intended recipient is prohibited by law and may subject them to criminal or civil liability. If you received this communication in error, please contact the sender.</p>	

Community Support Medication Program Website

<http://www.kdads.ks.gov/commissions/csp/behavioral-health/providers/grant-and-contract-supported-programs/community-supported-medication-program>