Crisis Response
NETWORK Eligibility & Care Services

Applicant Name (AKA): _____ Applicant DOB: _____

T19: ☐Yes ☐ No AHCCCS ID: _____ Health Plan: _____ T/RBHA: _____

Applicant Phone _____ Social Security # _____

Applicant email: _____

Gender: ☐ M ☐ F Gender Identity: ☐ M ☐ F Preferred Pronoun: ☐ He/Him ☐ She/Her ☐ They/Them

Preferred Language: _____ Preferred Communication: Bi-lingual staff / Braille / ASL / TTY Race: _____

Emergency Contact/Relationship: _____ Emergency Contact Phone: _____

Is there a guardian: ☐ Yes ☐ No Letters of Guardianship included: ☐ Yes ☐ No (if no, do not proceed)

Guardian Name/Address: _____

Applicant Mailing Address: _____ Applicant Residential Address: _____
_____ _____

Is applicant experiencing homelessness? ☐ Yes ☐ No

Date/Time SMI evaluation request was received: _____ _____ _____

Date/Time Consent was signed: _____ _____ _____

Where did the evaluation take place: ☐IP ☐OP ☐Jail Waiver: ☐3 days ☐20 days ☐90 days

Assessor _____ Credentials _____

Date of Preliminary Recommendation _____ Is applicant functionally impaired: ☐Yes ☐No

Is Applicant at Risk of Deterioration: ☐Yes ☐No Non-Qualifying Diagnosis: _____

Check if applicant <u>does not meet</u> SMI Criteria: ☐

SMI DX 1: _____ SMI DX 2: _____ SMI DX 3: _____ SMI DX 4: _____ SMI DX 5: _____

Packet Submission Contact 1: Name: _____

Phone: _____ Email: _____

Packet Submission Contact 2: Name: _____

Phone: _____ Email: _____

Clinical Contact 1: Name: _____

Phone: _____ Email: _____

Clinical Contact 2: Name: _____

Phone: _____ Email: _____