

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  EEP 30/60

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 does not meet 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: \_\_\_\_\_