



Applicant Name (AKA in AHCCCS): _____ Applicant DOB: _____

Region: ☐ North ☐ Central ☐ South AHCCCS ID: _____ Current Health Plan: _____

If Applicant is NT19 or not enrolled with AHCCCS, please indicate RBHA for Health Plan in Portal

If approved for SMI services, RBHA assignment will be: _____

If approved for SMI services (Maricopa County Only), preferred clinic assignment will be: _____

Applicant Phone # _____ Social Security # _____

Applicant email: _____

Gender: ☐ M ☐ F Identifies as: ☐ M ☐ F ☐ Non-Binary Preferred Pronouns: ☐ 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 Proof 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 requested: _____ Date/Time Consent was given: _____

Where did the evaluation take place? ☐ IP ☐ OP ☐ Jail

Waiver Option Selected: ☐ 3 days ☐ 20 days ☐ EEP

If applicant agrees to EEP, please indicate agency and location for EEP Services: _____

Assessor _____ Credentials/Position Held _____

Date of Preliminary Recommendation _____

Proposals: Applicant is ☐ Functionally Impaired (OR) ☐ at Risk of Deterioration (OR) ☐ does not meet SMI Criteria List

Non-Qualifying Diagnosis (NA if none): _____ List SMI Qualifying Diagnosis (NA if none): _____

Clinical Contact 1: Name: _____

Phone: _____ Email: _____

Clinical Contact 2: Name: _____

Phone: _____ Email: _____