

Central office action required:

Field/stakeholder review: Yes No

If yes, reviewed by:

Filing Instructions: Put on AMH Transmittal Webpage, email to include form and link to AMH Transmittal Webpage

If you have any questions about this policy, contact:

Contact(s):	Kelly C. Knight		
Phone:	503-945-5959	Fax:	503-378-8467
E-mail:	Kelly.C.Knight@state.or.us		

Addictions and Mental Health (AMH)

AMH ONLY

Date Received: _____ A/C Date: _____ Funding Source: _____

Date of Request: _____ Requestor Name: _____
 County: _____ Requestor Phone: _____
 Provider: _____ E-mail Address: _____
 Program: _____ Level of Care: _____

Click on type of contract: County Contract Direct Contract

Click on type of request: Add/Change Remove RSCP

If this is a Specific Client request, please provide the following client information:

Client **LAST** Name: _____ Client **FIRST** Name: _____
 Client DOB: _____ Is client PSRB / JPSRB? YES NO
 Client Income: Amount \$ _____ SSI SSDI VA Other; Describe: _____

Is this Client Medicaid Eligible? Yes. If yes, select OHP or OHP Plus
 No. If no, attach denial letter.
 Pending. If pending, date applied _____.

Note: Requestor is responsible for the accuracy of the Medicaid eligibility information.

Do you want a copy of the Letter of Intent (LOI) to be sent to other people?

Yes No

If yes, please provide the following information:

Name	Title	Program / Provider	Email

