COMMUNITY SUPPORT MEDICATION PROGRAM (CSMP)
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 KDADS Behavioral Health Services Commission [Explain in area below]

Mental Health Center assignment:_____

Authorized signature _____ Date_____

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

Fax Number_____

Fax enrollment form to: Chellie Ortiz Prescription Network Operations Director (785) 228-3951	**For KDADS Use Only:** ☐ Approved ☐ Not Approved _____ KDADS _____ Date
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Community Support Medication Program Website:

https://www.kdads.ks.gov/provider-home/providers/grant-and-contract-supported-programs/community-supported-medication-program