INDIVIDUALS AUTHORIZED TO SIGN
COMMUNITY SUPPORT MEDICATION ENROLLMENT FORM

Mental Health Center, State Mental Health Hospital or Other:

_____

Please note: Only individuals listed on this form will be considered for "authorizing" enrollment in the Community Support Medication Program.

CMHC/SMHH/OTHER staff authorized to sign Community Support Medication Enrollment/Disenrollment:
(Please print or type)

Name	**Title**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Submission of these names affirms that the individuals listed have read the Community Support Medication guidelines and are familiar with both the clinical and financial eligibility guidelines and regulations of the program.

_____ _____

Signature of CMHC Executive Director, SMHH Superintendent or Other — Date

Please fax this form to:
1) Chellie Ortiz, Operations Manager
   PNK
   785-228-3951
2) BHS Community Support Program Manager
   KDADS, Behavioral Health
   785-296-0256

For PNK Use Only:

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