mercy care	SMI Assessment Packet Checklist

Consumer Name:_____ DOB:_____

Client ID #: _____

Evaluator Name: _____ Date: _____

Provider Agency Name: _____

Provider Agency Phone #_____

Provider Fax #_____

Please submit completed forms and checklist to:

FAX: (888) 656-2659

1. ☐ Data Disposition Sheet
2. ☐ ADHS / DBHS Behavioral Health Client Cover Sheet
3. ☐ Additional Addenda: Seriously Mentally Ill (SMI) Determination
4. ☐ Assessment
5. ☐ Waiver of 3 Day Determination
6. ☐ Consent for Assessment for Level of Care
7. ☐ Notice of SMI Grievance and Appeal Procedure
8. ☐ Advance Directives Form
9. ☐ Releases of Information (ROIs)
10. ☐ Additional Records