

Children's Mental Health Program
Enrollment Form

Enrollee Name: _____

Medicaid ID#: _____

SSN: _____

Transition Services Coordinator: _____

Address: _____

Telephone: _____ Fax: _____ Date: ____/____/____

Placement Information:

Discharge Date to the Community: ____/____/____

Community Placement with:

- Parent(s) Guardian Other Relative Foster Care

Name: _____

Placement Address: _____

Telephone: _____

LDSS: _____ FIPS Code: _____

Eligibility Worker: _____

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DMAS-800

PURPOSE OF FORM—This form is used to advise the local department of social services (LDSS) of a child's enrollment in the Children's Mental Health Program.

USE OF FORM--Initiated by the Transitional Services Coordinator, the form advises the LDSS of the child's enrollment in the Children's Mental Health Program, the individual(s) with whom the child has been placed and the location of the residential address for the placement. Additionally, the file indicates to the LDSS that the child is to remain an assistance unit of one for purposes of the Medicaid financial eligibility determination.

NUMBER OF COPIES--Original and one copy for the LDSS Medicaid eligibility file.

DISTRIBUTION OF COPIES--Place the copy of this form in the services file and send the original to the LDSS Medicaid Eligibility Worker.