# NON-RESIDENT APPLICATION FOR PAYMENT OF TREATMENT SERVICES

This form must be used for clients who present for services and are not residents of the Lakeshore Regional Partners (LRP) region. Submit the form to your local CMHSP in which the client presents for service. For clients who are residents of another county within the LRP region contact that county's CMHSP Access Center to discuss. *** = Required Fields** *(Incomplete requests will not be approved.)*

Applicant (client) Name: Birth date:

Current Home Address:

County: Telephone: SSN:

***Current Family Income:**$_____ per wk ☐ mo ☐ yr☐ **# of Dependents + self:** **# of Dependent Children:**
***If income < $10,000/year,** describe other sources of support. Paid Leave, Unemployment, Disability, SSI, and FIP payments should be reported as income. Use separate page, if needed, to describe income sources or means of support.

***Does client have any health insurance?** Y☐ N☐ If yes, Company:

***Medicaid?** Y☐ N☐ **MIChild?** Y☐ N☐ **HMP?** Y☐ N☐

***Treatment agency/site** at which services are proposed: _____

***Levels of service** proposed, if known: Assessment☐ OP☐ IOP☐ Detox☐ Residential☐

***Name of contact person** at treatment facility, if known: _____

***Has client or provider contacted** the client's **home** PIHP Assessment Center for services? Y☐ N☐
Home PIHP response? _____

***Identify the reason** for seeking publicly-funded treatment services outside of client's home Coordinating Agency region. Mark the appropriate category listed below, or describe under "Other":

- ☐ I'm a priority category client, but unable to receive services in my home region.
  Check all that apply (confirmation may be requested):
  - ☐Pregnant
  - ☐Female caregiver of minor children
  - ☐Parent with active CPS/DHS/Court child custody case
  - ☐Communicable disease diagnosis: TB, HIV-AIDS, Hepatitis, Syphilis, or Gonorrhea
  - ☐Minor child of parent in treatment
  - ☐Injecting non-prescribed drugs in past 60 days.
- ☐ I work in the LRP region and want treatment near my place of work.
- ☐ The level or special type of care I need is not licensed or publicly offered within my county of residence or coordinating agency region (describe):
- ☐ Directed to a specific treatment program by a court/judge (*Must list source)
- ☐ I moved out of the LRP region less than 30 days ago and want to complete my treatment here.
- ☐ I'm homeless; I'm staying in Michigan but with no home address now or in last 30 days. My last permanent address was in _____(county) in _____ (state).
- ☐ Other (describe):

***Applicant Statement**: "I verify that the above information is truthful and accurate. I understand that I am seeking services outside of my home service area and may be responsible for the cost of the services I receive if local funds are not available." **Signature** of Applicant*_____ *Date* _____
***Signature** of Referring Professional*_____ *Date* _____

Reviewed by: _____ Date_____ Approved (if clinically appropriate)☐ Denied☐

Reviewer comments/conditions/limits: