



**STATE OF MONTANA**  
**DEPARTMENT OF CORRECTIONS**  
**DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES**  
**OFFENDERS WITH MENTAL ILLNESS**  
**SERVICES REQUEST FORM**

<b>NAME:</b> _____	<b>DOC ID#:</b> _____
<b>ADULT:</b> <input type="checkbox"/>	<b>DISCHARGE DATE:</b> _____

<b>OFFENDER ADDRESS:</b>	<b>P&amp;P REGION:</b>
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<b>Estimated Cost:</b>
<b>REASON FOR REFERRAL:</b>

<b>MENTAL HEALTH COUNSELOR/PROVIDER</b>	<b>NAME:</b>
	<b>ADDRESS:</b>
	<b>PHONE #:</b>

**TYPES OF SERVICES NEEDED:**

<input type="checkbox"/> Case Management	<input type="checkbox"/> Medication Monitoring
<input type="checkbox"/> Benefit Enrollment	<input type="checkbox"/> Clinical Assessment or Evaluation
<input type="checkbox"/> Housing assistance	<input type="checkbox"/> Group Clinical Services/Therapy
<input type="checkbox"/> Dedicated Prerelease Beds	<input type="checkbox"/> Individual Clinical Services/Therapy
<input type="checkbox"/> Emergency Counseling	
<input type="checkbox"/> Other, Please Explain: _____	

<b>Supervising Staff Signature</b>	<b>Date</b>	<b>Staff Manager's Signature</b>	<b>Date</b>

<input type="checkbox"/> <b>APPROVED</b>	<input type="checkbox"/> <b>DENIED</b>
<b>PRC/TX Program Manager</b>	<b>Date</b>

**RELEASE FROM PROGRAM:**

Benefit Enrolled;

Discharged Sentence;

New Crime;

Revocation/Return to Secure Care

Voluntarily left Program.

**COMMENTS:** \_\_\_\_\_

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