Department of Human Services, Health Services
Addictions and Mental Health Division (AMH)
500 Summer St. NE E86, Salem, OR 97301-1118
Phone (503) 945-5763 **Fax** (503) 378-8467

PSRB Community Treatment and Service Element Contract Amendment Request

Date of Request: _____

Requestor's Name: _____
Phone: _____
Email: _____
Fax: _____

Mental Health Program: _____

PSRB Client Information:
Client Name (Last, First): _____
Date of Birth (mm/dd/yyyy): _____
Medicaid Eligibility: **Y** or **N** Client Income: (**SSI, SSDI, VA, or GF, Other**)

Purpose of Request: (Monitoring and Supervision, Room & Board, Personal Incidental Funds, etc….See PSRB CR Checklist for a full listing)

Dates of Coverage		Description of Request: (I.e. Monitoring and Supervision, Room & Board, PIF, Treatment Services. Include Name of Provider of Service or Home)	Monthly Amount Requested (ongoing)	Total Amount Requested (one-time)
Begin (I.e 7/1/05)	End (I.e. 6/30/07)			

Additional Information: _____
_____
_____
_____

Please Fax Completed Request to: Elaine Sweet, PSRB Utilization Coordinator at (503) 378-8467.