

RUSH

DATE: ___/___/___

TO: FSD Greene County Office
101 Park Central Square
Springfield MO 65806
Greene.CoDFSIM@dss.mo.gov
Fax: 417-895-6080

Re: Department of Mental Health (DMH) consumer:

Name: _____

Date of Birth: _____

DCN: 0 0 _____

GAF score: _____

From DMH Agency/Provider:

Agency/Provider Name: _____

Address: _____

Contact Person: _____

Contact Phone Number: _____

Contact Email Address: _____

Documents Included:

- Application
- Authorized Representative Form
- MRT Packet (If a consumer is receiving SSDI the MRT Packet is not needed.)
 - IM-61B – Disability Questionnaire
 - IM-61C – Work History
 - IM-61D – Doctor/Medical Facility List
 - MO 650-2616 – Authorization for Disclosure
 - Medical Records
 - IM-60A – Medical Report including Physician’s Certification/Disability Evaluation
- Other _____

Only to be completed by Agency/Provider Representative.

**Do not submit without completing all sections of this form. Do not distribute this to consumers.
Use this form for applications that need to be processed quickly for the wellbeing of the consumer.**