DATE: _____

TO: FSD DBH Processing Staff
101 Park Central Square
Springfield MO 65806

FROM: Department of Mental Health/Division of Behavioral Health (DBH)

RE: MO HealthNet for Aged, Blind, or Disabled (MHABD) application and information for the following individual:

Applicant's Name: _____

Applicant's Date of Birth: _____

Applicant's DCN: _____

Please process this application following guidelines in IM Memorandum #89 (2013).

Current DBH facility name/address/ and contact person/phone number/email:

_____

_____

_____

_____

Anticipated discharge date for applicant: _____

Anticipated Community Mental Health Center (CMHC) name and contact information:

_____

_____

**Note: Actual discharge date and CMHC information will be provided by DBH staff when the discharge occurs.*