

State of Montana
DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
MONTANA MENTAL HEALTH SERVICES PLAN
Enrollment Application

| | |
|--------------------------|-----------------|
| <input type="checkbox"/> | New Enrollment |
| <input type="checkbox"/> | Re-enrollment |
| <input type="checkbox"/> | New Information |

Please complete this form with information specific to the applicant seeking services.

| | | | | | |
|--|-----------------------|---------------------|------------------------------------|---------------------------|--|
| Full Name of Applicant: _____ | | | Social Security Number: _____ | | |
| Last | First | MI | | | |
| Other Names used in past: _____ | | | | | |
| Mailing/Residence Address: _____ | | | | Education Level: _____ | |
| City, State, Zip: _____ | | | Current County of Residence: _____ | | |
| Home Phone #: _____ | | Work Phone #: _____ | | Message Phone #: _____ | |
| Date of Birth: _____ | Marital Status: _____ | Gender: _____ | Race: _____ | Tribal Affiliation: _____ | |
| Has the applicant ever served on active duty in the Armed Forces? Yes <input type="checkbox"/> No <input type="checkbox"/> <i>(Not counted are those whose only service was in the Reserves, National Guard or Merchant Marines)</i> | | | | | |
| Who is legally responsible for the applicant? <i>(circle one to specify)</i> Self Guardian Limited Guardianship | | | | | |
| Other <i>(specify)</i> _____ | | | | | |

| LIST EVERYONE WHO LIVES WITH APPLICANT. (Attach additional sheet if more than five people live with applicant.) | | | | | |
|---|--|-----|------------|-----------------|------------------------|
| Last Name, First, Middle Initial | How is this person related to applicant? | Sex | Birth Date | Education Level | Social Security Number |
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |
| 5. | | | | | |

| INCOME: SUBMIT VERIFICATION OF <u>ALL</u> INCOME FOR ALL HOUSEHOLD MEMBERS | | | |
|--|--------|------------------------|--------------------|
| List all income and benefits you, your spouse, dependents, or other household members receive from any source (i.e., employment, Social Security, SSI, Pensions, VA, Child Support, BIA, etc.) | | | |
| Name | Source | Gross Amount of Income | How Often Received |
| | | | |
| | | | |
| | | | |
| | | | |
| If Zero income, what is your source of support? _____ | | | |
| Do you anticipate this income to change in the next two months? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |
| If yes, what is the expected change: _____ | | | |
| Number of Family Members Dependent on Family Income? _____ | | | |

PLEASE LIST THE MENTAL HEALTH CARE PROVIDER(S) AUTHORIZED TO RECEIVE COPIES OF MHSP CORRESPONDENCE

Name: _____ Agency: _____

Address: _____ Phone #: _____

City, State, Zip: _____

Name: _____ Agency: _____

Address: _____ Phone #: _____

City, State, Zip: _____

DO YOU HAVE HEALTH INSURANCE COVERAGE? Yes No

(If yes, please complete the following for all insurance coverage including Medicare. **ATTACH COPY OF CARDS**)

Name of Insured: _____ Relationship to Applicant: _____

Insured's SSN: _____ Policy # _____ Group # _____

Insurance Carrier Name: _____ Start Date: _____

Insurance Carrier Address: _____ End Date: _____

ARE YOU RECEIVING MEDICARE: Yes No

I hereby declare that all statements and answers to the above questions are complete and true to the best of my knowledge and belief. I agree that they shall form a part of the insurance contract for which I am applying. I hereby authorize any licensed physician, medical practitioner, hospital, clinic, organization, institution or person that has any records or knowledge of my health to disclose to Department of Public Health and Human Services (DPHHS) or its designee any such information. A photographic copy of this authorization shall be as valid as the original. I may revoke this authorization at any time except to the extent that the person or entity making the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate one year from the date that I sign.

I agree to notify DPHHS at _____ of any changes of income, family size or other insurance coverage within 30 days of the change.

Signature of Applicant: _____ **Date:** _____

This application is considered complete only when income documentation has been attached.

**Please mail to:
Benefit Management Team
Attn: Linda Nelson
Addictive & Mental Disorders Division
PO Box 202905
Helena MT 59620-2905**

**Or Fax to:
Benefit Management Team
Attn: Linda Nelson
1-406-444-4435**