State of Montana
DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
Addictive & Mental Disorders Division
Medicaid Enrollment Application

☐ MHSP (Detention Center)
☐ WASP (Standard Medicaid)

Mental Health Services Plan (MHSP) and Waiver for Additional Services and Population (WASP)

Please complete this form with information specific to the applicant seeking services
NOTE: This form needs to be submitted with the Clinical Eligibility Form

APPLICANT INFORMATION		
Applicant ID/SSN:	DOB:	Gender:
Applicant Name: Last:	First:	Middle:
Mailing Address:	City:	State:
County:	Zip:	
Telephone #:		
Tribal Affiliation:	Race:	Marital Status:

For Detention Center Use:

Detention Center_____City/County_____Discharge/Disposition Date_____

First Date of Service Seen in Detention Center _____

LIST EVERYONE WHO RESIDES WITH APPLICANT**.** (Attach additional sheet if more than three 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.					

INCOME: SUBMIT VERIFICATION OF **ALL** 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.) **2 months** of pay stubs.

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 ☐No

If yes, what is the expected change? _____

Number of family members dependent on family Income? _____

Applicant Name: Last: _____ First: _____

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

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: _____

ARE YOU RECEIVING MEDICARE**:** ☐Yes ☐No Medicare ID #

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 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 or Fax the Checklist, Application and Clinical Eligibility Form to:

Addictive & Mental Disorders Division

Mental Health Services Bureau
PO Box 202905, Helena MT 59620-2905

Please send through secure method (such as ePass) to:
HHSAMDDMHSPWaiver@mt.gov

Fax: 1-406-444-7391 or
1-406-444-4435 Questions? Call
1-406-444-3964

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