

State of Montana
DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
Behavioral Health and Developmental Disabilities Division
Clinical Eligibility Form
Waiver for Additional Populations (WASP)

APPLICANT INFORMATION

Date of intake appointment: _____ Referred by: _____
Applicant ID/SSN: _____ DOB: _____ Gender: _____
Applicant Name Last: _____ First: _____ Middle: _____
Mailing Address: _____ City: _____ State: _____
County: _____ Zip: _____ Telephone #: _____

Applicant's stated reason for seeking services:

NOTE: This form needs to be submitted with the Medicaid Enrollment Application

PROVIDER AGENCY INFORMATION

Name: _____ Clinician email address: _____
Address: _____ City: _____ State: _____
Zip: _____ Telephone #: _____ Fax #: _____

CLINICAL INFORMATION

CURRENT DSM5/ICD-10 DIAGNOSES:

Please list both code and narrative, including substance use disorders.

Primary Diagnosis: _____ Specifiers Required: _____

Other (requiring treatment): _____

Medical Conditions (specify):

*List signs/symptoms to substantiate the qualifying SDMI primary diagnosis:

Name of Medication:	Dose / Frequency:	Prescriber:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Applicant Name- Last:		First:	
If no current medications, has a medical professional with prescriptive authority determined that medication is necessary to control the symptoms of the mental illness?			Yes <input type="checkbox"/> No <input type="checkbox"/>
Name and title of medical professional:			
History of adult outpatient mental health treatment:			Yes <input type="checkbox"/> No <input type="checkbox"/>
Please list any services in which the individual has participated, including individual and/or family therapy:			
History of Inpatient Adult Mental Health (NOT CD) Treatment:			Yes <input type="checkbox"/> No <input type="checkbox"/>
Number of Acute Psychiatric Admissions:		Date of most recent admission:	
Number of Montana State Hospital Commitments:			
Date of most recent commitment:			
Reason for most recent admission:			
Is the individual unable to work/school full time due to mental illness ?			Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, briefly describe:			
Is the individual unable to work/school full time due to mental illness ?			Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, briefly describe:			
Is the individual unable to care for themselves due to mental illness ?			Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, briefly describe:			
Is the individual homeless or at risk of homelessness due to mental illness ?			Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, briefly describe:			
Current Risk Factors (e.g. suicidal ideation/plan, danger to others, history of abuse impacting current functioning):			
Proposed Treatment Plan (identify services, i.e. medications, CM, OPT, etc.):			

"I certify I am the person who performed face-to face clinical assessment and the above statements are true and correct."

Provider Signature: _____

Date: _____

Printed Name: _____

Date: _____

Supervisors Signature: _____

Please Mail or Fax the Checklist, Application and Clinical Eligibility Form to:
Behavioral Health and Developmental Disabilities Division Mental Health Services Bureau
PO Box 202905, Helena, MT 59602-2905
Fax: 1-406-444-7391 or 1-406-444-4435

Please send through a secure method:
Montana File Transfer Service to:
HHSBHDDWASPWaiverApps.mt.gov

Questions? Call 1-406-444-3187 • Email: Tracey.Palmerton@mt.gov