

MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES (DPHHS)
 BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES DIVISION (BHDD)

**APPLICATION FOR CERTIFICATION AS A
 MENTAL HEALTH PROFESSIONAL PERSON (MHPP)**

PART I – APPLICANT INFORMATION

A. BASIC INFORMATION

Name: Click or tap here to enter text. Date: Click or tap here to enter text.
 Mailing Address: Click or tap here to enter text. City, State, Zip: Click or tap here to enter text.
 Phone #: Click or tap here to enter text. Personal Email: Click or tap here to enter text.

B. EMPLOYMENT INFORMATION

Name of Employer: Click or tap here to enter text. Position/Title: Click or tap here to enter text.
 Address: Click or tap here to enter text. City, State, Zip: Click or tap here to enter text.
 Work Phone: Click or tap here to enter text. Work Email: Click or tap here to enter text.
 Counties you will be serving as a MHPP: Click or tap here to enter text.

C. EDUCATION AND TRAINING

List below your education and training directly related to professional license:

Name & Location of School	Major/Degree	# of Years Attended	Dates Attended/Completed
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.

List below the education/training CEUs received for your professional license for the past year or attach a list (must follow your professional license requirement): list attached

Name of Program	Title of Training	CEUs	Dates Attended/Completed
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.

MHPP Certification Application, Part I cont.

Name of Applicant: Click or tap here to enter text.

D. PROFESSIONAL LICENSE INFORMATION

License Type (LCSW/LCPC): Click or tap here to enter text. MT License #: Click or tap here to enter text.

Original Date Issued: Click or tap here to enter text. Expiration Date: Click or tap here to enter text.

Are there any adverse actions on your professional license: Yes No

If Yes, please explain: Click or tap here to enter text.

Other License/certification: Click or tap here to enter text.

E. LETTER OF APPLICATION

Write a letter of application that includes the following:

Click or tap here to enter text.

1. Your reason(s) for applying for certification;
2. Your understanding of the statutory responsibilities of a mental health professional person;
3. Describe how you stay current in the field of mental health and substance use disorder, as well as the resources available through the State of Montana; and
4. Explain your process of reviewing policies, statutes, regulations, and policies (e.g., federal, state, and local).

I certify that the above information is true to the best of my knowledge:

Applicant Signature: Click or tap here to enter text.

Date: Click or tap to enter a date.

Return this form and all supporting documents to:

MHPP Certification Committee
Behavioral Health and Developmental Disabilities Division (BHDD)
PO Box 202905
Helena, MT 59620-2905
Fax: 406-444-7391 or -9389
Email to YGentile@mt.gov