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 III – REFERENCES

TO THE APPLICANT: The MHPP application requires three references from peers who can comment on your qualifications as a licensed mental health professional, as well as to provide the information requested. Type your name and the name of a person who can comment on your qualifications on each form. The completed forms must be sent directly to the Certification Committee by the referee, not the applicant.

APPLICANT NAME:

REFEREE NAME:

Dear Referee:

You have been asked to provide information regarding the above-named applicant's qualifications to be certified as a Mental Health Professional Person by the State of Montana. Please answer each of the questions below as completely as possible.

1. How long have you known the applicant in a professional capacity?

2. Describe your professional relationship with the applicant.

3. During your professional relationship, how often do (did) you have contact with the applicant?

4. Describe the reasons for the contacts.

5. Have you read any reports the applicant has written concerning the mental status and treatment needs of persons living with serious mental illness? ◯ Yes ◯ No ◯ Not sure
   If yes, please comment on the applicant's skill in this area.

6. To your knowledge, has the applicant had experience evaluating persons with serious mental illness?
   ◯ Yes ◯ No ◯ Not sure
   If yes, please comment on the applicant's skill in this area.

Name of Applicant:

7. To your knowledge, has the applicant had experience treating persons with serious mental illness?
   ◯Yes ◯No ◯Not sure
   If yes, please comment on the applicant's skill in this area.

8. Have you had the opportunity to observe the applicant taking part in meetings where the client's treatment plan was developed or reviewed?
   ◯Yes ◯No ◯Not sure
   If yes, please comment on the nature and extent of the applicant's contribution to the discussion.

9. In your opinion, is the applicant knowledgeable about the full range of mental health services available throughout Montana?
   ◯Yes ◯No ◯Not sure
   If yes, please comment on the nature and extent of the applicant's knowledge.

10. To your knowledge, how does the applicant stay current on the changes in the field?

11. What evidence, if any, have you observed regarding this applicant's knowledge and understanding of the laws, regulations, and policies that pertain to the rights of persons living with severe mental illness in Montana?

12. To your knowledge, how does the applicant stay updated on any and all changes to the laws, regulations, and policies in the mental health field both federally and locally?

13. Do you recommend this applicant for certification as a MHPP?
   ◯Yes ◯No ◯Not sure
   If yes, please explain.

14. Other comments (optional).

Name of Applicant:

I certify that the responses I have given to the above questions represent my best and most complete knowledge regarding the applicant's qualification to be a certified MHPP. I understand the important responsibilities that Montana law gives to the certified MHPP which includes evaluating persons with severe mental illness for possible commitment and institutionalization, providing expert testimony at commitments hearings, and other duties and responsibilities listed in ARM 37.91.402.

Print Name and Title: Position:

Signature: 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 Jen.coen@mt.gov