

MHSP Waiver Checklist
Addictive and Mental Disorders Division – State of Montana
FAX – 406 444 7391 or 406 444 4435
Secure EMAIL – HHSAMDDMHSPwaiver@mt.gov

Name: _____ Referring Provider: _____

Participant SSN: _____ DOB: _____ Date Received: _____

To be included in Application Packet:	Completed	
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|--|-----------|----------|------------|
| 1. MHSP Application – <u>Required</u> | _____ Yes | _____ No | |
| 2. Clinical Eligibility Form/ & Assessment – <u>Required</u> | _____ Yes | _____ No | |
| 3. Does client have current MHSP Eligibility? | _____ Yes | _____ No | |
| 4. Applied for Medicaid-Required (if yes date) | _____ Yes | _____ No | Date _____ |
| 5. Does client currently receive SNAP benefits? | _____ Yes | _____ No | |
| 6. Proof of U.S. Citizenship – <u>Optional</u> | _____ Yes | _____ No | |
| 7. Proof of Identification – <u>Optional</u> | _____ Yes | _____ No | |
| 8. Medicare Card (works for ID and Citizenship) | _____ Yes | _____ No | |
| 9. Current Paystubs or SSDI award letter –
(within 2 mo.) - <u>Required</u> | _____ Yes | _____ No | |
| 10. Insurance card (other insurance) | _____ Yes | _____ No | |
| 11. Social Security Card | _____ Yes | _____ No | |

Date of Clinical Assessment (Cannot be older than 2 years): _____

****Eligible SDMI Diagnoses with severity specified of moderate or severe are listed below (NOS does not qualify) . Please mark the primary diagnosis indicated in the Clinical Assessment.**

- A. Schizophrenia Disorder _____
- B. Bi Polar Disorder _____
- C. Major Depressive Disorder _____
- D. Anxiety Disorder _____
- E. Post-Traumatic Stress Disorder _____
- F. Borderline Personality Disorder _____
- G. Other (Explain) _____

Contact Name: _____ Date: _____

Mailing Address: _____

Phone Number: _____ Fax Number: _____

Email: _____

Signature: _____

By signing your name electronically, you agree that this form has been completed accurately to the best of your knowledge.