

State of Montana
DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
MONTANA MENTAL HEALTH SERVICES PLAN
Non-Medicaid Enrollment Application

<input type="checkbox"/>	New Enrollment
<input type="checkbox"/>	Re-enrollment
<input type="checkbox"/>	New Information

Please complete this form with information specific to the applicant seeking services.

Full Name of Applicant: _____ Social Security Number: _____
Last First MI Maiden
 Name of Parent/Guardian, if applicant is a minor: _____
Last First MI Maiden
 Mailing/Residence Address: _____ Education Level: _____
 City, State, Zip: _____ Current County of Residence: _____
 Home Phone #: _____ Work Phone #: _____ Message Phone #: _____

Applicant Date of Birth:	Marital Status:	Sex:	Race:	Tribal Affiliation:
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Emergency Contact: _____ Emergency Contact Phone Number: _____
 Best Method of Contacting the Applicant: _____
 Head of Household Name and Social Security Number: _____
Has the applicant ever served on active duty in the Armed Forces? Yes No
(Not counted are those whose only service was in the Reserves, National Guard or Merchant Marines)
Who is legally responsible for the applicant? *(circle one to specify)* Self Parent Guardian Grandparent Guardian Limited
 Child Protective Services Dept of Corrections Bureau of Indian Affairs Other *(specify)* _____

LIST EVERYONE WHO LIVES WITH APPLICANT. (Attach additional sheet if more than five 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.					
4.					
5.					

INCOME: SUBMIT VERIFICATION OF ALL INCOME

List all income and benefits you, your spouse, dependents, or other household members received from any source (i.e., employment, Social Security, SSI, Pensions, VA, Child Support, BIA, etc.) **WITHIN THE PAST YEAR**

Name	Source	Gross Amount of Income	How Often Received

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? _____

RESOURCES:

How much to the members of your household have in liquid resources such as cash, checking, savings, Stocks, or bonds: \$ _____

Excluding the home you live in, do you own or co-own any real-property? Yes No
If yes, what is the value of your property?

Please list all vehicles, including recreational vehicles you own or own with others and the value of each vehicle:

Vehicle: _____ Value \$ _____ Vehicle: _____ Value \$ _____
Vehicle: _____ Value \$ _____ Vehicle: _____ Value \$ _____

PLEASE LIST THE MENTAL HEALTH CARE PROVIDER AUTHORIZED TO RECEIVE COPIES OF MHSP CORRESPONDENCE

Name: _____ Agency: _____
Address: _____ Phone #: _____

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: _____
Insurance Carrier Address: _____ End Date: _____

ARE YOU RECEIVING MEDICARE: Yes No

If applicant is child under 19 have you applied for CHIP Benefits? Yes No

Have you received a decision of eligibility or denial from CHIP? Yes No

Please attach a copy of the denial or eligibility letter from CHIP.

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 at _____ 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 to:

Benefits Management Team
Addictive & Mental Disorders Division
P. O. Box 202905
Helena, MT 59620-2905